

WHOSE ETHOS? WHOSE ETHICS?

**The Contributions of Anabaptist Theology and Ethics to
Contemporary Biomedical Ethics**

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DECLARATION

I hereby declare that I have composed this dissertation and that it is original material not previously submitted for another degree or professional qualification.

Sylvia M. Klauser
05 June 2002

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ABSTRACT

This dissertation argues for the inclusion of Radical Reformation Theology into the discussion of contemporary biomedical ethics. Historically, Anabaptist/Mennonite theology has not had a place in the development of biomedical ethics. Catholic moral theology and various definitions of Protestant theological ethics have shaped the field of biomedical ethics alongside several important philosophical theories. A combination of such theological and philosophical theories of biomedical ethics has been the result of the *Belmont Report* and has later been expanded into *The Four Principles of Biomedical Ethics* with its focus on autonomy, beneficence, maleficence, and justice.

However, the empirical research among Anabaptist/Mennonite physicians shows that such theories do not make adequate reference to Anabaptist/Mennonite theology and ethics and its approach to agent-based virtue ethics. This theology emphasises servanthood as the *model* for the physician, peace and non-violent justice as the *modus operandi* for this servanthood model, and community as the sustaining and sending *forum* for such servanthood. If these perspectives were included in the contemporary discussion of biomedical ethics, the virtuous agent would be enabled to embody a reconciling relationship- the physician with the patient and vice versa. In Anabaptist/Mennonite theology, agency formation has high priority and happens through the model of observation-participation-embodiment. Theology is therefore observed, participated in, and embodied by the individual agent within the setting of community.

Such an agent-focussed approach that seeks consensus in biomedical ethics would help to balance a principled approach that seeks to find the lowest common denominator. This agent-based approach could also aid in the process of uncovering the blind spots of contemporary biomedical ethics such as injustices in health care access and resource allocation, discriminatory policy-making, and the favouring of a largely utilitarian-deontological pragmatism in biomedical ethics.

The voice of Anabaptist/Mennonite theology is comparatively young, and barely experienced enough, to be heard loudly. However, the adolescent voice of this theology of embodiment may have broken, and a sustainable vision for an Anabaptist/Mennonite biomedical ethics might hopefully be found in the pages of this research.

ABBREVIATIONS

Journals, Dictionaries, Encyclopaedias

AB	Anabaptist
CC	Christian Century
CDP	Cambridge Dictionary of Philosophy
EBE	Encyclopaedia of Bioethics
CG	Conrad Grebel Review
CD	Church Dogmatic
COD	Concise Oxford Dictionary
DNTT	Dictionary of New Testament Theology
HCR	Hastings Centre Report
JME	Journal of Medical Ethics
JMP	Journal of Medicine and Philosophy
JRE	Journal of Religious Ethics
KD	Kirchliche Dogmatik
KIEJ	Kennedy Institute of Ethics Journal
ME	Mennonite Encyclopaedia
MH	Medical Humanities
MHJ	Mennonite Health Journal
MQR	Mennonite Quarterly Review
NE	Nicomachean Ethics
ODCC	Oxford Dictionary of the Christian Church
SJT	Scottish Journal of Theology
TS	Theological Studies
QHR	Qualitative Health Research
ST	Summa Theologica

Theological and Medical Terminology

ART	Artificial Reproductive Technology
AZT	Zidovudine, Retrovir
CMDS	Christian Medical and Dental Association
CO	Conscientious Objector
CPS	Civilian Public Service
IVF	In Vitro Fertilisation
IUD	Intrauterine Device
MC-USA	Mennonite Church USA
MCC	Mennonite Central Committee
MEDA	Mennonite Economic Development Association
MDS	Mennonite Disaster Service
MHA	Mennonite Health Assembly
MMA	Mennonite Medical Association

ABBREVIATIONS

MWC	Mennonite World Conference
HMO	Health Maintenance Organisation
MVS	Mennonite Voluntary Service
PID	Pre-implantation Diagnostic
PVS	Persistent Vegetative State
SET	Student Elective Term
TOP	Termination of Pregnancy

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INTRODUCTION TO THE DISSERTATION

Biographical Note

This dissertation is the academic accumulation of two previous careers and years of experience of working with people. In my first career as a Massage and Lymphatic Therapist in Germany I was first introduced to questions and issues of biomedical ethics by working with women who battled the after effects of breast cancer. While trying to alleviate some of their physical problems such as fluid retention, skin lesions, and other immobility problems, we also talked about what treatment would be advisable next, whether to take the prescribed medication or not, when it was a wise decision to refuse any more chemotherapy, and a host of other questions that burned on the women's minds. We did not only talk about physical and medical questions. Often our discussions ended in pressing problems about death, about dying, about loss of physical features that resulted in the loss of self-esteem, and often ended in the loss of partners and loved ones. I encountered similar questions in geriatric physiotherapy, which made up the other half of my work as a therapist. Here the issues were related, but of a different nature.

In geriatric physiotherapy issues often revolve around mental competence and autonomy. In the setting of a rest home funded by the Swiss government, we encountered the entire spectrum of age-related issues in medicine. Besides issues of competence and autonomy, we encountered questions of family relationships and power of attorney issues, elder neglect by family, questions of the mentally and emotionally handicapped elderly persons who have been with us long-term, paralysis after stroke or invasive surgery, broken hips, complications in end stage diabetes, Alzheimer and Parkinson's disease, to name but a few. Many questions of care and therapy were concentrated on issues of financial resource management. In discussions with medical staff and family members, issues of biomedical ethics abounded, often with few or no answers. My work in this setting prompted me to continue further education, and I decided on a degree in counselling.

After receiving a Divinity degree with a specialisation in Pastoral Counselling from Mennonite Brethren Biblical Seminary in Fresno, CA, I was called to become an associate minister in a Mennonite Brethren Church in California. My responsibilities there were, among other things, overseeing and organising the work of long-term pastoral care. This included our Sunday School class for developmentally disabled adults, as well as the care and visiting of our elderly in the

congregation who needed long term care. Soon I encountered similar questions to those I had found in my previous career, both physical and spiritual/emotional in nature. As a minister I had more time to explore interconnections between physical, spiritual and emotional health with the parishioners. Many times the questions were also practical in nature: should we get a living will, and if so, what should it say? Should I have another, stronger medication, even though there are worse side-effects? How far should we go to have our own biological children? How long should we leave Grandpa on life support, and who is authorised to make a decision to withdraw treatment? Even though I thoroughly loved and enjoyed my work as a minister in this congregation, and even with a seminary degree, it quickly became apparent to me that my education in the field of biomedicine and ethics was inadequate for dealing with such questions properly and professionally.

The accumulation of these experiences as therapist and minister prompted me to focus my dissertation on the intersection between theology and biomedical ethics. It is my experience that when we talk to people who deal with life and death issues, the question of God, afterlife, pain, suffering, purpose of life, and many related issues come to the fore. But it is also my experience that physicians are often not equipped to deal with such questions from their patients, be that because of time pressure, differing ideologies, or just simply because of an inability and unwillingness to talk with the patients about such things. For some physicians the reason not to engage in religious discussions might just be the physician's knowledge that social workers and chaplains are responsible to discuss these themes with the patients. Since the patients are often left to their own devices in making life-altering ethical decisions, biomedical ethics could offer help and support in dealing with such issues. It is at the intersection of biomedical ethics and theology that this dissertation is situated, and it is at this intersection that I hope to situate my teaching career in Christian Ethics as well.

Structural Note

The writing of this dissertation has been accompanied by a continuous question; it is the same question that is a perpetual issue in practical theology: the inter-relation between theological theory and empirical practice. Does one begin research with the practical account/experience and then work out the appropriate theory? Or would it be academically more correct to begin with the theoretical account and then supply the practice? This very question was slowly amounting to a problem when designing the structure of the dissertation. The first draft was designed

to explain Anabaptist theology first and then use the empirical study to show how this theology is embodied in the physician's practice. The second draft began with the empirical study quickly the interview analysis, then proceeded to Anabaptist theology that shows the historical and theological grounding of the empirical work. The argument of the dissertation did not change in either of the drafts, and neither did the structure influence the strength of the argument in any way.

The reason why the final version begins with the empirical study and interview analysis is twofold: methodological and theological. First of all, the choice of the grounded theory approach, that has been used for this dissertation, strongly suggests that the first step is to let the data 'speak' for itself, and that conceptualisation of the data only follows as a second step.¹ In this dissertation it seemed vital as well to let the data speak and to let significant themes emerge before any conceptual connections with Anabaptist theology could be attempted. Secondly, it appears that current theological discussion is increasingly trying to include aspects of embodiment or embodied theology.² The main reason for beginning with the practical rather than the theoretical part was the interviewed physicians' stress on embodying their theological and ethics convictions. This dissertation argues in a similar vein to embodiment theory in theology, namely, that theology always occurs in historical particularity and that is it more effectively narrated as a story rather than as a theoretical system.³ Because of the strong commonality between embodied theology and Anabaptist theology and ethics, it seemed to be a perfect fit to begin with the embodied practice and then supply the theological system that grounds such embodiment.

Another important reason why this dissertation begins with practice is the emphasis on qualitative research. What emerges from this research is a focus on a biographical-narrative account of the physician's life and medical experience rather than a focus on the accumulation of numbers and statistics. The narratives about how the physicians find meaning, substance, and goals for their healing art seems to have

¹ Glaser, Barney, G. *Basics of Grounded Theory Analysis*. (Mill Valley, CA: Sociology Press, 1992). 11-12.

² McClendon, James, Wm. Jr. *Ethics: Systematic Theology, Vol. I*. (Nashville: Abingdon Press, 1986). *Doctrine: Systematic Theology, Vol. II*. (Nashville: Abingdon Press, 1994). *Witness: Systematic Theology, Vol. 3*. (Nashville: Abingdon Press, 2000). Adams, Nicholas and Charles Elliot. "Ethnography Is Dogmatics: Making Description Central to Systematic Theology." *Scottish Journal of Theology* 53, no. 3 (2000): 339-346. Woodhead, Linda. "Can Women Love Stanley Hauerwas? Pursuing an Embodied Theology." In *Faithfulness and Fortitude: In Conversation with the Theological Ethics of Stanley Hauerwas*, by Mark Thiessen Nation (et. al.) (Edinburgh: T&T Clark, 2000). 161-188.

³ Linda Woodhead, "Can Women Love Stanley Hauerwas?" 187.

emerged as one of the fundamental results. This dissertation is more interested in the shaping and forming forces on the physician's life rather than in the accumulation of statistical material. This dissertation wants to discover the voice of the physician in the daily struggle to be an authentic Anabaptist/Mennonite Christian and authentic physician.

After many discussions, and after more trial and error drafts of this work, I decided that the dissertation should begin with the empirical part and then introduce the theology dimension. This structure appears to be more beneficial to the overall understanding of Anabaptist/Mennonite theology and ethics and its contributions to contemporary biomedical ethics.

Cultural Note

The cultural setting of this dissertation is in the USA and Canada. Because I was interested in Anabaptist/Mennonite theology and its contributions to biomedical ethics, the first priority was to locate potential research subjects who practise in the medical field. The Mennonite Church USA has a professional medical organisation called Mennonite Mutual Aid (MMA). All of the volunteers for this study know about, or are members of MMA. In addition, all of the volunteers are from either the US or from Canada therefore, the empirical research is focussed on North America. However, this fact does not imply that the findings of this dissertation are limited to the US or Canada, quite to the contrary. It will have to be the focus of further research to show that the theological principles found in this dissertation could be employed and embodied by physicians regardless of nationality, gender, or even creed.

The original idea for this research was to compare North American, European, and maybe Latin American and/or African Mennonite physicians, in order to find out the unifying theological principles for their work. However, due to space and time restrictions, this idea had to be deferred for the time being. The idea of a comparative study of Mennonite physicians in different countries can still be attempted as a future research project.

Theological Note

This dissertation has been written with the hope of introducing Anabaptist/Mennonite theological and ethical thoughts into the field of biomedical ethics. Since this dissertation has been written for a university in the United Kingdom, it was of particular importance to produce a thorough, but concise introduction to the Anabaptist legacy of Radical Reformation theology. It has been a

balancing act on two fronts. One problem was to reduce the vast amount of historical material about Anabaptist/Mennonite theology and ethics to an appropriate minimum-without losing the core message of the theology. On the other hand I needed to supply enough theological insights to provide the empirical study with a credible conceptual framework.

The other balancing act in writing about Anabaptist/Mennonite theology was to construct a credible argument for a theology that has historically been subject to extraordinary persecution at the hands of the Reformers. Anabaptist/Mennonite theology has had a very slow recovery towards acceptance as a credible theology. The recovery has been greatly advanced by the works of theologians and historians such as Harold S. Bender⁴, Guy. F. Hershberger⁵, and most recently through John Howard Yoder⁶ and Stanley Hauerwas.⁷ The relative silence around Anabaptist/Mennonite theology and ethics as a whole might have precluded this theology from being part of the bioethics discussion in the early 1960s; the history of Mennonite medical services, however, does tell a different story. In the past the Mennonite contributions to biomedical ethics have been embodied by many health care professionals rather than discussed in theological or other theoretical circles. It was the embodied praxis of the Anabaptist/Mennonite health care workers that provided the first impulse for research in this area to find out how the actual practice really corresponds with Anabaptist/Mennonite theology.

Thesis Statement and Research Questions

Contemporary biomedical ethics seems to have settled on a combination of moral theology, utilitarian theory, and deontological responsibility approaches. In an attempt to be as inclusive as possible, this seems to be a pragmatic approach that tries to include as many voices as possible in the process of policy making. The impact of Beauchamp and Childress' *The Principles of Bioethics* has been undisputed for the last several decades.⁸ These principles evolved from the *Belmont Report*, the first

⁴ Bender, Harold, S. *The Anabaptist Vision*. (Scottsdale PA: Herald Press, 1944). Bender, Harold, S. and C. Henry Smith. *Mennonites and Their Heritage: A Handbook of Mennonite History and Beliefs*. (Scottsdale: Herald Press, 1964).

⁵ Hershberger, Guy, F. (ed.) *The Recovery of the Anabaptist Vision*. (Scottsdale, PA: Herald Press, 1957).

⁶ Yoder, John Howard. *The Politics of Jesus: Vicit Agnus Noster*. (Grand Rapids, MI: Eerdmans, 1994²). The superscript number at the end of the publishing date denotes the edition of the book. *Balthasar Hubmaier: Theologian of Anabaptism*. (Scottsdale, PA: Herald Press, 1989).

⁷ Hauerwas, Stanley. "When the Politics of Jesus Makes a Difference." *Christian Century* 110, October 13 (1993): 982-985.

⁸ Beauchamp, Tom, L., Childress, James. *The Principles of Biomedical Ethics*. (New York: Oxford University Press, 1994⁴).

bioethics report commissioned by the Department of Health, Education and Welfare in the 1970s.⁹

Because contemporary bioethics is mainly concerned with universal principles and unifying public policy issues, it is argued that it lost some of its early emphasis on the responsibility of the physician in his/her relationship to the patient. It is in the area of the agency of the physician where *this dissertation wants to show that Anabaptist/Mennonite theology and ethics have an important contribution to make in contemporary biomedical ethics*. The guiding research questions were

1. Is there an influence of theology and ethics on the Anabaptist/Mennonite physician's practice of medicine? If there is such an influence, what is it, where has the influence first been recognised, and how does this theology and ethics influence the physician today?
2. If there is an influence of theology and ethics on the physician's practice, what would the defining characteristics of such theology be, and how can such influences be utilised in the discussion of biomedical ethics today?
3. If there are specific characteristics in Anabaptist theology and ethics that are important in the physician's practice, have these characteristics been introduced into biomedical ethics already? If they have not been introduced yet, how can they best be utilised in questions of contemporary biomedical ethics?

Structure of the Dissertation

Chapter I of the dissertation provides a brief account of theological and philosophical theories that have been instrumental in the early development of bioethics. This chapter introduces us to four contemporary theological voices in biomedical ethics, the Catholic ethicist Lisa Sowle Cahill, and Laurie Zoloth, a Jewish ethicist; the mainline Protestant scholar James Gustafson, and the theological ethicist Stanley Hauerwas in the Methodist tradition. There was no particular reason to choose these four theologians, except that each represents a different theological voice with unique and significant contributions in the area of moral theology and contemporary biomedical ethics. In the second part of this chapter we are introduced to the significant influence of Thomas Beauchamp and James Childress' book *The*

⁹ Jonsen, Albert. *The Birth of Bioethics*. (New York/Oxford: Oxford University Press, 1998). 102-104. Cf. Cassell, Eric. J. "The Principles of the Belmont Report Revisited: How Have Respect for Persons, Beneficence, and Justice Been Applied to Clinical Medicine?" *HCR* 30, no. 4 (2000): 12-21.

Principles of Biomedical Ethics, among students often referred to as ‘the mantra’. This book seems to have become the basis for a principlist approach in biomedical ethics, and it is this approach that is introduced in the second part of this chapter. After the discussion of a principlist approach, virtue ethics is introduced and discussed in light of a principlist approach. We also find a discussion on a Christian approach to virtue ethics, which seems to have some commonality with the ethical approach found in the research among Anabaptist/Mennonite physicians.

In *Chapter II* we are introduced to the empirical research and the research methodology. We are lead through the entire research project from its initial conception, to the first contacts with volunteers, to the pilot study interviews, and finally to the main research interviews. The choice of qualitative research was made in light of the nature and concept of Anabaptist/Mennonite theology, a theology that emphasises quality relationships and connectedness. In addition, biographical narrative analysis seemed to be the most compatible analytical tool for this research, because Anabaptist/Mennonite theology is a strongly narrative based theology. The grounded theory approach, with its emphasis on the emergence of themes and topics, provided the most theoretically appropriate concept for this dissertation. Chapter II concludes with a statement of the demographic data from the research interviews and thereby prepares the way for the analysis of the research interviews.

Chapter III begins with a brief description of the process of transcribing. This is followed by the introduction of the emerging themes through some interview excerpts. The emerging themes are organised into theological themes and philosophical themes. Under the heading ‘theological themes’ we find excerpts that deal with questions of service, compassion, caring, peace, justice, non-violence, access, questions about community, and support for patients as well as for physicians. Philosophical themes are placed around issues of life style and tolerance.

In part one of Chapter III we begin with the process of coding the emerging themes, which is the list of all the themes that have emerged after the first, preliminary reading of the interviews. Then we will approach the analysis of theological content under their distinct headings. There is first *servanthood as a model for physician conduct*, where we try to analyse the implications for the physician who makes servanthood his/her model for professional conduct. Then we find the themes of *peace and non-violence as the motivational force for servanthood*. Here we try to see what kind of influence the Anabaptist/Mennonite peace theology could have on the attitude of the physician in his/her patient relationship. In the last

part of this section we investigate *community as forum for servanthood and peace and non-violent justice*, where we try to understand the inextricable link between servanthood, peace and non-violent justice, and community from an Anabaptist perspective.

In *Chapter IV on Anabaptist Theology and Ethics* we are leaving the realm of empirical research and entering the world of theology. It is here that we establish the corresponding conceptual framework between the practice of the physicians and Anabaptist/Mennonite theology. In part I we are introduced to the historical developments that led to the establishment of Anabaptist theology. It is in this part that we find a significant link between the Anabaptist confession of faith and its strong emphasis on discipleship, which has led Anabaptist/Mennonites to embody their theology rather than talk about it. The practice of discipleship seems to revolve around a tripartite pattern of observation-participation-embodiment. This pattern clearly emerges from the empirical research. Interview excerpts will tell us how this pattern of discipleship has occurred in the personal biographies of the interviewed physicians. In part two of this chapter we find a discussion of the theological theory of the embodied practice that we found in the first part of this chapter as well as in the interview excerpts in Chapter III.

In *Chapter V* we discuss and link the emergent themes of servanthood, peace and non-violent justice, and community with the Anabaptist/Mennonite scholarship of John Howard Yoder. Yoder is probably the best-known Mennonite scholar of the late 20th century. His scholarship has focussed primarily on peace and justice issues, an emphasis that provided him with academic credibility far beyond his own denominational boundaries and catapulted him into the world wide ecumenical discussion of the last decades of 20th century. His exceptionally detailed scholarly work has been the basis for, and challenge of, this chapter. However, it can be shown that the themes emerging from the interviews with the physicians find a strong correspondence with Yoder's interpretation of the same themes. Moreover, we could not only verify the existence and similarity of the same theological themes, we also found that Yoder's life and ministry followed a similar pattern to the ones the physicians described for us. It appears in this chapter, that Yoder's theological understanding of servanthood, peace and non-violent justice, and particularly of community are exceptionally suitable as a theological basis of an Anabaptist Biomedical ethics.

Finally, it was the burden of *Chapter VI* to apply the emergent themes to questions in contemporary biomedical ethics. In part one of this chapter we discussed how servanthood as model for physician conduct could be applied to questions at the beginning of life, at the end of life, and to questions of justice in health care. We found that the physician who practises servanthood would be able to emphasise three areas that are so far underemphasized in biomedical ethics. Such emphasis is presupposed by the physician's main focus on a very good relationship with the patient. If this relationship is given, the physician can practise a) stewardship of limited resources and be clear about the limitations of medicine. In a good physician-patient relationship there also has to be b) stewardship of interconnections, where the communication of physician and patient is clearly expressed in the honest admission of many interconnected layers of problems that come in the guise of questions of biomedical ethics. Lastly, the physician can then practise c) stewardship of limitations with his/her patients. This means that the physician can be very clear and very frank about what medicine can or cannot do and which medical treatments would be life-enhancing.

In part two of Chapter VI we found that if peace and non-violent justice is the *modus operandi* for the physician, then he/she can try to emphasise *maintaining life* and *maintaining relationship* in questions at the beginning of life. With the questions at the end of life there is still the emphasis on maintaining relationships with the patient, but the second stress would be on appropriately *releasing life*. In questions of justice in health care the physician will emphasise *advocacy*, *involvement*, and *creative change*.

In part III, community emphasis was the main focus. Here we found three distinct ways in which the community can make a significant difference in the life of the physician and the patient. Both the physician and the patient need the sustaining and sending community to deal with the many questions in biomedical ethics. In the last part we found that the community itself can become the basis for the embodiment of a holistic approach to theology.

In the *Concluding Chapter* at the end of the dissertation we find a final discussion of the proposed thesis of this dissertation. We conclude the discussion with an integrative look at the title of the dissertation as well as some thoughts about the process of writing this dissertation. These thoughts include the hope for further study on various themes that emerged from this dissertation, but it also emphasised the goal of this dissertation. One goal for this dissertation was to put together an

academic work that can be used by MMA and other Anabaptist/Mennonite health care workers to enhance the embodiment of their theology in their respective vocations. A secondary goal for this work was to provide the academic stimulus for the development of an Anabaptist approach to biomedical ethics. However, the main goal, and proposed thesis statement, of this dissertation was to show that Anabaptist/Mennonite theology and ethics indeed provide important contributions to questions of contemporary biomedical ethics.

CHAPTER I

CONTEMPORARY THEOLOGICAL AND PHILOSOPHICAL VOICES IN BIOMEDICAL ETHICS

Introduction to the Chapter

The concentration of this introductory chapter is to establish the conceptual framework for this dissertation. The main concern of this dissertation is the contribution of theological voices to contemporary biomedical ethics. In particular, this dissertation wants to describe the contributions of Anabaptist Theology to the field of biomedical ethics. In order to establish the appropriate context we need a brief, yet compact account of past involvement of theological voices in biomedical ethics. Theological voices have been leading the early discussion in biomedical ethics. These theological contributions first emerged largely from within Catholic moral theology or mainline Protestant theological ethics. The voice of Radical Reformation theology, which has been overlooked by mainline Protestant theology in the past, has also not been heard among the theological voices in biomedical ethics. This dissertation wants to rectify such lacking contribution of the Anabaptist/Mennonite voice by demonstrating that this theological approach is one of ‘embodiment’¹⁰; such theological embodiment can best be observed in the practice of Anabaptist/Mennonite health care workers.

The geographical setting of this dissertation is in North America because the volunteering research subjects all came from the USA or Canada. Given the space restrictions, references to important developments in British and continental European approaches in biomedical ethics are limited to the footnotes.

In the first part of this chapter we will begin with the introduction of four contemporary writers and their contributions to the current bioethics debate. In an attempt to describe the wide variety of contributions in biomedical ethics these four contributors are from distinctly different theological tradition: Lisa Cahill is a Catholic moral theologian, and Laurie Zoloth is from an Orthodox Jewish background, whereas James Gustafson is mainline Protestant and Stanley Hauerwas calls himself a radical Protestant. After the introduction of these ethicists, we will

¹⁰ Throughout this dissertation, single quotations are used as ‘scare quotes’, when a particular concept is specifically emphasised, or when a new concept is highlighted; double quotation marks indicate only quotations that are referenced in the footnotes.

then be introduced to current issues in contemporary biomedical ethics as they surface from the scholarly work of the chosen authors.

In the second part of the chapter we will be introduced to the principlist concept in biomedical ethics and the concept of virtue ethics. As the main protagonists of the respective concepts we chose Beauchamp and Childress' *Principles of Biomedical Ethics* for the principlists, and *Christian Case for Virtue Ethics*, as proposed by Joseph Kotva. After the initial introduction of these two models we will discuss the differences and commonalities of the principled approach and the virtue ethics approach in biomedical ethics. We will conclude this chapter with a discussion of virtue ethics in its non-religious as well as religious forms, and will point towards an Anabaptist theological embodiment as it seems to evolve from the Christian approach to virtue ethics.

In this chapter we will find that even though theological voices have been formative in the beginning of biomedical ethics, such voices have slowly become quieter. Theological voices seem to be rare in the public discussion of biomedical ethics today; it is not that the religious voices have been sidelined on purpose, says Daniel Callahan, it is more that "they have been bypassed for the most part".¹¹ If mainline theological voices are few in biomedical ethics today, are there other theological positions that could speak up be considered about issues in biomedical ethics?¹² Are there theological approaches that have not yet been explored in depth, and could make a serious contribution in biomedical ethics today? Are there specific contributions that Anabaptist/Mennonite theology can make to questions in biomedical ethics, and if so, what might they be? It is around these questions that this dissertation is located.

This dissertation seeks to emphasise the contributions of Anabaptist/Mennonite theology and ethics to contemporary biomedical ethics. This Radical Reformation theology has a unique theological and ethical principles to contribute to the discussion in contemporary biomedical ethics which have not yet been explored, and its voice could become increasingly important. After setting the academic stage for this dissertation, particular Anabaptist/Mennonite principles will be introduced, which emerge from the analysis of the empirical research in Chapter II and Chapter

¹¹ Callahan, Daniel, "Religion and the Secularisation of Bioethics", HCR: 20:4, July/August 1990. Special Supplement. 1-4.

¹² Non-mainline theological voices denotes theologies outside of the mainline paradigm of Roman Catholic and Protestant theology, such as Baptists, Radical Reformation/Believers church traditions, or Pentecostal/revivalist traditions, to name only a few.

III. Anabaptist/Mennonite principles will also be the main focus in Chapter IV, centring on an in-depth discussion of Anabaptist/Mennonite theology and ethics. The connection between Anabaptist/ Mennonite doctrine and confession will be highlighted, moving towards an understanding how this particular interpretation of theology and ethics has developed and how it is embodied today. In Chapter V we will discuss the theological and ethics contributions of John Howard Yoder, one of the best -known Anabaptist theologians of the 20th century. Finally, in Chapter VI, Anabaptist/Mennonite principles will be employed in current issues of contemporary biomedical ethics in order to provide examples of their validity and viability.

I. CONTEMPORARY THEOLOGICAL VOICES IN BIOMEDICAL ETHICS

Definition of terms and cultural setting of the dissertation

In this dissertation the term theories of biomedical ethics denotes concepts that are currently prevalent in biomedical ethics reasoning.¹³ The term theories includes theological as well as philosophical constructs. It is of great importance to understand the theoretical constructs of these theories before the outline of an Anabaptist theology and ethics can be attempted in Chapter IV.

Another definition of terms is needed here: Throughout this entire dissertation the term ‘biomedical’ ethics will be used, a term which needs to be defined here. This is a combination of ‘medical ethics’ and the term ‘bioethics’, which refers mostly to ethical matters as they result from new advances in biological sciences. Bioethics is a comparatively new discipline that is interested in “the systematic study of the moral dimension of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting”.¹⁴ Bioethics seems to have become an academic theory, whereas medical ethics seems to be seen as the field where new bio-scientific research is clinically practised. It appears that from the 1970s onwards, academic bioethics gained a new dynamic and developed into an academically acknowledged discipline.¹⁵ Instrumental to the development of the field of bioethics were several federal commissions in the USA – in 1974, the National

¹³ Beauchamp, Tom, L. and James Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1994⁴).

¹⁴ Warren Reich as quoted in Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998). vii.

¹⁵ Jonsen, Albert and Andrew Jameton, “History of Medical Ethics: The Americas,” in *Encyclopaedia of Bioethics* by Warren T. Reich, ed. (New York: Simon and Schuster, 1995⁴). 1627.

Commission for the Protection for Human Subjects, and the 1979 President's Commission with its subsequently published *Belmont Report*.¹⁶

The history of medical ethics on the other hand, is as old as the healing professions¹⁷ and seems to be the field of applied in questions of clinical practice. Medical ethics in the USA underwent drastic changes in the 20th century. These changes seem to have contributed in significant ways to “the changing role of hospitals, the predominance of science and technology, and the development of specialisation,” argue Albert Jonsen and Andrew Jameton.¹⁸ Traditional medical practice changed most drastically with new discoveries in bacteriology, pathology and physiology, which led physicians towards much narrower specialisations of specific fields of medical science, and the medical generalist was slowly replaced by the medical specialist. In addition, new medical boards had to be established for these new scientific discoveries to oversee the explosive growth of new medical specialities. Medicine seemed to move from being a service for the people to being seen as service to specialised fields, leading to “complaints that physicians had lost their ability to care for the whole person”.¹⁹ Medical specialists who knew one area of medicine particularly well seemed to replace the generalist physician who conceptualised the whole patient.

While academic bioethics became a discipline in its own right through the last 30 to 50 years, medicine and medical ethics underwent drastic changes as well. This change was largely to contribute to the introduction of Health Maintenance Organisations (HMO) in the USA. Even though specialised medical care seems to be the dominant paradigm for much of the first world, renewed interest in the area of medical humanities might be a step towards “complementing medical science and technology through the contrasting perspective of arts and humanities, and to refocus the whole of medicine in relation to an understanding of what it means to be fully human”.²⁰ Questions surrounding the entire field of humanities in bioethics are constant discussions within the *American Society of Bioethics and Humanities*, in

¹⁶ Callahan, “Religion and the Secularisation of Bioethics.” 3.

¹⁷ Darel Amundsen, “The Early Christian Tradition” in *Caring and Curing: Health and Medicine in the Western Religious Tradition* by Roland L. Numbers and Darel W. Amundsen. (New York: Macmillan, 1986). 40-64.

¹⁸ Cf. Jonsen and Jameton “The History of Medical Ethics: The Americas,” *EBE*: 1616.

¹⁹ Jonsen and Jameton “The History of Medical Ethics: The Americas,” *EBE*: 1617.

²⁰ Greaves, David and Martyn Evans, “Medical Humanities,” *Medical Humanities, Edition of the Journal of Medical Ethics* 26, no. 1 (2000): 1-2.

conferences and journals, and are particularly addressed in specific panels and workshops.

As we will see in the remainder of this dissertation, Anabaptist/Mennonite physicians seem to emphasise a similar need for greater integration of the academic discipline bioethics with the practice of medicine and its related ethical questions. In an attempt for continuous discussion between bioethics and medical ethics, this dissertation therefore uses the term 'biomedical' ethics. Since it is beyond the scope of this dissertation to provide a comprehensive understanding of biomedical ethics, this dissertation will focus only on the most current developments from the early 1960s onwards.

Space restrictions do not allow for dealing with each individual theologian and philosopher presently active in biomedical ethics nor is it possible to include all past participants in this field. Therefore contemporary theologians from distinctly different religious backgrounds have been chosen and will be introduced along with their major publications. This selective pattern allows us to do in-depth research on questions of contemporary biomedical ethics. In the second part of this chapter we will discuss the differences between the universalist or principled and the virtue ethics approach in contemporary biomedical ethics. The chapter will conclude with an introduction to Christian virtue ethics, since it is this ethical approach that seems to have the closest connection to the embodiment of Anabaptist/Mennonite theology in the lives and careers of Mennonite physicians.

A) Contemporary Voices In Biomedical Ethics

1. Lisa Sowle Cahill is a Christian Ethicist in the Catholic tradition. She is one of a number of ethicists educated in the 1960s in Chicago.²¹ She teaches at Boston College in Massachusetts, and is the editor and co-editor of several scholarly journals.²² Among her publications are *Can Theology have a Role in Public Bioethical Discourse*; *The Ethics of Genetic Engineering*; *Embodiment, Morality, and Medicine*; *Understanding Veritatis Splendor*, and *Sex, Gender, and Christian*

²¹ Jonsen, *Birth of Bioethics*, 64. Cf. Stanley Hauerwas, "Christian Ethics in America (and the JRE): A Report on a Book I will not write," *Journal of Religious Ethics* 25 (1998): 57-76.

²² Editor of *Concillium*, Previous co-editor of *Journal of Religious Ethics* and the *Journal of Medicine and Philosophy*.

Ethics.²³ In her essay “Embodiment and Social Critique” she provides a clear account of the social, physical, and emotional need for the connectedness of the human person.²⁴ She addresses the need to re-orient our compartmentalised and reductionistic concept of the human body along the lines of Judeo-Christian understanding of the body as a temple of God. Such an interpretation, she says, would provide ethics in biomedicine with significant views: one is the “importance of compassion towards the sick,” which will, secondly, lead to a better realisation “that we too (the caregivers) must die”. Thirdly, this recognition of vulnerability leads to understand the need “to socially integrate the practise of health care by alleviating suffering while acknowledging death”.²⁵ With this last statement Cahill points to a significant problem in modern biomedical ethics, namely a tendency to compartmentalise the human being and treat it as a spare parts store. This attitude has not only been criticised through ethical considerations in human tissue donations,²⁶ but it is also the basis of criticism of the increasingly gene-focused interpretation of personhood. For instance, pre-implantation genetic diagnostic (PIGD) not only helps to determine the health of the foetus, it also offers the opportunity to choose the sex of the child, as published in a recent article in a British daily newspaper.²⁷ Moreover, gene irregularities seem to receive increased attention, promising treatments for heart diseases, late-onset diabetes, and obesity, to name just a few. These diseases have long been classified as behaviourally based physical problems and need to be treated with a combination of behavioural changes by the patients and through medical attention by the physician. Identifying genes as the sole reason for such physical problems, could take away the individual's responsibility to be actively involved in lifestyle changes.

²³ Lisa Cahill, “Can Theology have a Role in Public Bioethical Discourse.” *HCR* 20, July/August (1990). Maureen Junker-Kenny and Lisa Sowle Cahill, *The Ethics of Genetic Engineering*, vol. 2, *Concilium* (London/Maryknoll: SCM Press, Orbis Books, 1998), Lisa Sowle Cahill and M.A. Farley, *Embodiment, Morality, and Medicine* (Dordrecht: Kluwer Academic Press, 1995), Lisa Sowle Cahill, *Understanding Veritatis Splendor: The Encyclical Letter of John Paul II on the Church's moral teaching* (London: SPCK, 1994), Lisa Sowle Cahill, *Sex, Gender, and Christian Ethics* (Cambridge: Cambridge University Press, 1996).

²⁴ Cahill, “Embodiment and Social Critique,” *On Moral Medicine*. 401-412.

²⁵ Cahill, “Embodiment and Social Critique,” *On Moral Medicine* 411.

²⁶ Human tissue donations in the context of this dissertation include all human tissue, such as cadaver organs, egg, and sperm.

²⁷ *Daily Telegraph*, July 5, 2001. 10. Cf. Herta Daeubler-Gemlin, “Selektion ist nicht akzeptabel,” *Die Zeit*, 31:4, July 26, 2001. Barbara Duden, “Frauen ohne gute Hoffnung,” *Die Zeit*, 31:26, July 26, 2001.

In a recent article called "Genetics, Commodification, and Social Justice in the Globalisation Era" Cahill criticises current practices of gene modification even more severely.²⁸ Her criticism reaches beyond an increasing instrumentalisation of patients for the sake of research, for she adamantly asserts that genetic globalisation has subjugated developing countries for the profit of the rich west. She calls for a multi-faceted approach to what she calls "wrongful subordination," a term coined first by Margaret Radin in *Contested Commodities*.²⁹ According to Cahill, an increasingly widespread genetification of society will lead to more commercialisation, and such exploitative practice needs to be continuously challenged by a religious, social and legal response.³⁰

This article puts Cahill squarely in a long tradition of Catholic moral theologians who stress the need for understanding human connectedness to creation and to the Creator God, including the need for our human reasoning to be informed by faith if it is to serve the greater good of humanity. This means for Cahill that our human ways of understanding have to be reflected on in light of scripture, and in this sense she is true to the Catholic moral (natural) theological tradition.

Empirical evidence can be appropriated meaningfully in Christian ethics only if interpreted in the light of other, complementary sources: Scripture, tradition, and normative, as distinct from description accounts of the human.³¹

It seems imperative for Cahill to combine her theological and ethical training with current and relevant scientific evidence. This emphasis becomes most clear in her book *Sex, Gender, and Christian Ethics*. In the chapter "The body in context," she sets the stage for a contextualised approach to personhood: a person lives as a body, with a body, and through a body (all in singular voice) towards a body (in plural voice), the body of Christ in this world, the church.³² In light of her position in Catholic moral theology, Cahill reflects on current questions in artificial reproduction. Her assessment of the situation is based on three crucial reports, the *Warnock Report* (1984), *Donum vitae*, the Vatican's Instruction on Human Life (1987), and *Infertility*, the report of the Office of Technology Assessment in the USA

²⁸ Cahill, Sowle, Lisa, "Genetics, Commodification, and Social Justice in the Globalisation Era," KIEJ:11, no. 3, 221-238.

²⁹ Cahill, "Genetics, Commodification, and Social Justice in the Globalisation Era," 231. Cf. Margaret Jane Radin, *Contested Commodities*, (Cambridge, MA: Harvard University Press, 1996).

³⁰ Cahill, "Genetics, Commodification, and Social Justice in the Globalisation Era," 231.

³¹ Lisa Sowle Cahill, "Using Empirical Information" in *From Christ to the World: Introductory Readings in Christian Ethics* by Wayne Boulton (et. al.) (Grand Rapids, MI: Eerdmans, 1994) 179.

³² Cahill, *Sex, Gender, and Christian Ethics*. 73-107.

(1988).³³ Her resulting questions help to uncover six “neglected areas of moral concern” in regard to artificial reproduction. These areas of neglect can be most easily summarised in the following questions: what does it mean to personhood to have human relationships in reproduction (or the lack thereof), and how can a woman/man be supported in their quest for biological offspring without being coerced into technological options just because they are in a position to afford such options?³⁴

In her scholarship, Lisa Cahill seems to follow a similar pattern to that found in the historical ethical scholarship of Bernhard Haering and Father Richard McCormick.³⁵ She acknowledges the increasingly compartmentalised concept of person in biomedicine, but she refuses to bow down to an issue-driven agenda. She rather stresses the need for awareness of socio-economic, psychological, and religious factors which drive our needs for certain biomedical procedures. In her feminist critique of IVF treatment, she stresses the need for close examination of our means to ascertain ends in biotechnology.³⁶ Cahill’s continuous stress on a holistic outlook in the discourse between Catholic moral theology and questions in biomedical ethics should certainly be highly appreciated in the current ethical debate.

2. Laurie Zoloth is another articulate female voice in contemporary biomedical ethics. Her theological grounding, however, is in the Jewish tradition. She was most recently president of the American Society of Bioethics and Humanities. She is professor and chair of the Jewish Studies Program at the San Francisco State University in San Francisco, as well as an active member of her local Orthodox Synagogue. Together with Sue Rubin she founded *The Ethics Practise* in Berkeley, CA, and is a member of the Nations Bioethics Advisory Board. She publishes extensively in *The Journal of Clinical Ethics*, *The Hastings Centre Report*, and *The*

³³ Cahill, *Sex, Gender, and Christian Ethics*. 220-241.

³⁴ Cahill, *Sex, Gender, and Christian Ethics*. 240.

³⁵ Cf. Bernhard Haering, *The Law of Christ*, Vol. 1-3, (Westminster, MD: Newman Press, 1966). *Das Heilige und das Gute: Religion und Sittlichkeit in ihrem gegenseitigen Bezug*. 1950. *Medical Ethics*, (South Bend, IN: Fides, 1973). *Manipulation: Ethical Boundaries of Medical, Behavioural, and Genetic Manipulation*. (Slough: St. Paul Publication, 1975).

McCormick Richard and Paul Ramsey, *Doing Evil to Achieve Good: Moral Choice in Conflict Situation* (Lanham, MD: University Press of America, 1985). “Moral Theology and the Genome Project”, in *Controlling our Destinies: Historical, Philosophical, Ethical, and Theological Perspectives on The Human Genome Project*, by Phillip R. Sloan (ed.) (Notre Dame, IN: University of Notre Dame Press, 2000). 417-427. “Theology and Bioethics,” in *On Moral Medicine: Theological Perspectives in Medical Ethics*, by Stephen Lammers and Allen Verhey (ed.) (Eerdmans, 1998). 63-71

³⁶ Cahill, *Sex, Gender, and Christian Ethics*. 254.

Journal of Medicine and Philosophy.³⁷ As a contemporary bioethicist, she is deeply engaged in the *Human Embryonic Stem Cell Debate*, as the title of one of her edited books suggests.³⁸ As the author of numerous scholarly articles she is known for her frankness about, and commitment to Judaism as the religious basis for her academic work. In an article entitled "Jordan's Bank: A View from the First Years of Human Embryonic Stem Cell Research", she points to three crucial foci from which she starts this debate: there is

a), telos, the practical medical ends and speculative but foreseeable correlative ends as they affect our ontological notions of person, aging and death, then, b), there is process with questions of origin, power, derivation, special concerns for women, consent, and lastly, c), there is [the importance of] context including justices commodification, and implications of research work.³⁹

Zoloth, along with her academic colleagues Suzanne Holland and Karen Lebacqz, is a very eloquent spokesperson for two distinct issues in biomedical ethics research: she strongly advocates the concern for, and treatment of women in biomedical ethics, and secondly, she severely criticizes the increasing commodification of tissue donations, especially gametes donations.

The theological basis for her work is most clearly, and very obviously, Judaism. Her recent book *Health and the Ethics of Encounter: A Jewish Discussion on Justice*⁴⁰ and *Second Text: Essays Toward a Feminist Jewish Bioethics* are clearly based on her theological engagement with Jewish Scriptures.⁴¹ Like her Catholic counterpart Cahill, Zoloth not only focuses on bioethics, she also has a keen eye for the treatment of women and minorities and the ways in which justice in health care is applied to these two groups. The theme of justice is also an important theme for the

³⁷ Holland, Suanne, "Profile: Laurie Zoloth-Passionate Progressive". *ASBH Exchange* Vol. 4, No. 1:3, Winter 2001.

³⁸ Holland, Suzanne, Karen Lebacqz, and Laurie Zoloth. *The Human Embryonic Stem Cell Debate: Science, Ethics, and Public Policy* Basic Bioethics, ed. Glenn McGee and Arthur Caplan. Cambridge, MA: MIT Press, 2001.

³⁹ Zoloth, Laurie. "Jordan's Bank: A View from the First Years of Human Embryonic Stem Cell Research." In *The Human Embryonic Stem Cell Debate: Science, Ethics, and Public Policy*, ed. Suzanne Holland, Karen Lebacqz, and Laurie Zoloth, 223-241. Cambridge, MA: MIT Press, 2001. 225.

⁴⁰ Zoloth, Laurie. *Health Care and the Ethics of Encounter: A Jewish Discussion of Justice*. (University of North Carolina Press, 1999).

⁴¹ Cf. Zoloth, Laurie: *Second Text: Essays Toward a Feminist Jewish Bioethics*. (forthcoming).

Anabaptist/Mennonite physicians in this study, and an in-depth discussion on justice will be found in Chapter IV and V later in the dissertation.

Through the discussion of the two previous theological ethicists several issues seem to have surfaced which could be classified as women's issues. Some of these issues are the focus of the following discussion.

Women's Issues in Biomedical Ethics

It seems that from the previous discussion several important issues arise for biomedical ethics. The most important issue, for Cahill as well as for Zoloth, seems to be the question of commodification of donated organs and gametes tissue. This includes live and cadaveric organs, egg and sperm donations, and embryonic tissue as used in genetic research. The main concern about donations are based in the second important issues, the issue of justice in biomedical ethics and all its effects on our understanding of personhood. Justice and personhood are not free-floating entities, unconnected to any social or economic environment, argues Zoloth:

“[There has to be] passion for just citizenship, for the idea that broad social liberation must take place in a responding and listening community. Next is the consideration for the vulnerable stranger. Finally, Jewish thought reminds us that that the world we stand in now is our only as stewards, and we will have to reflect carefully beyond the rhetorical flourish of that phrase to core issues of regulation and tough standards of enforcement...In our cautious deliberations of telos, process, meaning, and justice, we will have to place in the foreground the essential ethicist's question of whether this is a right act and what makes it so, of how this act can repair a broken world, or of whether it might not find a place in a world so broken we cannot forget our responsibility to support the extraordinary gestures of research science that such a discovery represents.”⁴²

Justice, social connectedness, effects of research on the individual in his/her social and economic environment, as well as the mandate and possibility for further research are well balance in Zoloth's statement of what she understands to be important issues in contemporary biomedical issues. There seems to be a tangible tension in Zoloth statement that seeks truthfulness to her work as a Jewish ethicist as well as support for controversial genetic research. It might be the continuous and

⁴² Zoloth, Laurie. "The Ethics of the Eighth Day: Jewish Bioethics and Research on Human Embryonic Stem Cells." In *The Human Embryonic Stem Cell Debate: Science, Ethics, and Public Policy*, ed. Suzanne Holland, Karen Lebacqz, and Laurie Zoloth, 97-111. Cambridge, MA: MIT Press, 2001. 109.

tenacious academic work that gives her the authority to speak with integrity on the issues of justice for women and minorities in contemporary biomedical ethics.

We need to keep the issues of justice and commodification at the top of the discussion list in contemporary biomedical ethics in the same way as Cahill and Zoloth have made those topics a high priority in their scholarship. Commodification, not only of donated tissues, but of most parts of the entire human person, seems to be one of the greatest dangers in biomedical ethics of the 21st century. Using the human body as a commodity for spare parts, and thereby separating the physical human being from the emotional and spiritual human being, is an issue where justice and commodification in biomedical ethics intersect. There seems to be an increasing ideology in biomedical ethics to rationalise the use of organs and other body parts, thereby dividing and separating the human person into compartments for body, spirit, emotion, and psyche.⁴³ These issues will be major part of the discussion later in this chapter, when we deal with the larger issues of how principlist and virtue ethicists would approach issues in biomedical ethics. Such a fundamental discussion will not be resolved in this chapter, but it has to be described here as it seems to be one of the major topics in the current debate in contemporary biomedical ethics. However, before we are prepared to approach the described discussion, we need to investigate two of the leading theological ethicists. Not incidentally, James Gustafson could be interpreted as a principlist supporter, whereas Stanley Hauerwas can safely be called as a virtue ethicist with communitarian leanings.

3. James Gustafson

In a similar vein as the discussed female theologian-ethicists, but with seemingly different methodologies, writes James Gustafson, an important figure in 'early' contemporary Protestant theological ethics, His *Theology and Ethics*⁴⁴ and *Ethics from a Theocentric Perspective*⁴⁵ are among his earlier and probably most directive publications on the relationship between theology and ethics. The context of his theological interpretation is found in the relationship between theology and

⁴³ The act-utilitarianism of Peter Singer is a good example here. Cf. Singer's *Wie sollen wir leben? Ethik in einer egoistischen Zeit*. (Muenchen: Deutscher Taschenbuch Verlag, 1999). *Practical Ethics*. (Cambridge: Cambridge University Press, 1993²). See also Elisabeth Bech-Gernsheim. *The Social Implications of Bioengineering*. (New Jersey: Humanities Press, 1995). Cf. footnote 69 below.

⁴⁴ Gustafson, James, M., *Theology and Ethics*. (Oxford: Basil Blackwell, 1981).

⁴⁵ Gustafson, James. M., *Ethics from a Theocentric Perspective* (Chicago/London: University of Chicago Press, 1984).

piety, in the interconnectedness of theology and religious tradition, in the tension between theology and how things are, and in the relationship between theology and ethics. As an analytical thinker, Gustafson insists on a systematic analysis of theological, as well as philosophical, source before attempting ethical considerations. In his *Protestant and Roman Catholic Ethics* he advances several reasons why Christian ethics can be called Christian. Gustafson's first thesis is that "the organising prospective, metaphor, analogy or principles of any comprehensive theological ethics must be developed so that four distinguishable base points, or points of reference, are coherently related to each other".⁴⁶ These four points are a) the interpretation of God's relationship to the world and to human beings, b) the interpretation of human experience, c) the interpretation of humans as moral agents, and d) the interpretation of how humans ought to make choices and judge personal actions.⁴⁷ In his second thesis, Gustafson points to several issues which need to be constant features for theological ethics. For "a comprehensive and coherent Christian theological ethics" there must be adequate reference to historically identifiable Christian sources. Along with scientific methods and information about which there is little dispute, philosophical methods and principles need to be considered to come to an adequate Christian ethic. And lastly, a comprehensive Christian theological ethics needs to consider "human experience broadly, including consequences of a theological ethics when applied to human action".⁴⁸ While his deceased predecessor Ramsey pragmatically applied biblical scripture to modern situations in medical ethics⁴⁹, Gustafson always seems to need more information before arriving at an ethical conclusion. And even after he has inquired about every conceivable argument and counter argument, he is still reluctant to be as directive as Ramsey. It is indisputable, however, that Gustafson has been one of the leading voices in Protestant theological ethics in the USA over the last half of the 20th century.

Gustafson's early publications centre around ideas of the Christian community being influenced by, and dependent on God's self-revelation in Christ who is "the focal point of the integrity and the coherence such as it is, of the Christian community, he is, or may be, the focal point of the integrity and coherence

⁴⁶ Gustafson, James, M., *Protestant and Roman Catholic Ethics* (London: University of Chicago Press, 1978). 139-140.

⁴⁷ Gustafson, *Protestant and Roman Catholic Ethics*. 140.

⁴⁸ Gustafson, *Protestant and Roman Catholic Ethics*. 142.

⁴⁹ Cf. Ramsey, Paul, *Ethics at the Edges of Life: Medical and Legal Intersections*. (New Haven: Yale University Press, 1978). *Basic Christian Ethics*. (London: SCM Press, 1953).

of the lives of those who are his followers”.⁵⁰ Because the influence of the Christian community on the individual agent is important in the shaping of the agent, Gustafson is very clear about the Christian community being Christian in their reliance on the Christian scriptures and the historical source of Christianity. In fact, it is Gustafson who has challenged Christian theologians to be true to their faith and to truthful application of Christian theological ethics in all realms of life.

Christian ethics is the intellectual discipline that renders an account of this experience and that draws the normative inferences from it for the conduct of the Christian community and its members. The practical import is to aid the community and its members in discerning what God is enabling and requiring them to be and to do.⁵¹

In his later publications, Gustafson continually challenges his readers to think about nature from a theocentric perspective.⁵² Wholly in the frame of Reformed theological interpretation of Creator-redeemer-sustainer, Gustafson blames contradictory human thinking for our misunderstandings about the Creator-creation relationship. He understands humans to be co-creators with God which allows, even morally requires, full human participation in bio-scientific progress.⁵³ This focus on full human participation in creation as co-creators earned him quite significant criticism, notably from his former colleague Stanley Hauerwas. In the book *James M. Gustafson's Theocentric Ethics: Interpretations and Assessments*, he is also criticised for his “global revisionist perspective”.⁵⁴ True to this charge, Gustafson seemingly displays a revisionist perspective. In an article called “A Response to Critics,” Gustafson deals with five theological critics who have read and remarked on this two-volume theological work. In this article, he very articulately challenges his critics to engage in serious ethical discussion, rather than hide behind religious platitudes. It seems that Gustafson does not tolerate uncritical and dogmatic thinkers who seemingly refuse to engage constructively with our rapidly changing world from their theological perspectives. McCormick, Cahill, Hauerwas, Toulmin, and Ramsey

want nothing from other ways of construing the world to affect their theologies; indeed I infer that they find that quite threatening. And none of them...does justice to the ways in which piety and tradition interpenetrate

⁵⁰ Gustafson, James M., *Christ and the Moral Life* (New York/London: Harper and Row, 1968). 241.

⁵¹ Gustafson, James M., *Can Ethics Be Christian?* (Chicago/London: The University of Chicago Press, 1975). 179.

⁵² Gustafson, James M., *A Sense of the Divine: The Natural Environment from a Theocentric Perspective* (Cleveland, OH: Pilgrim Press, 1994).

⁵³ Gustafson. *A Sense of the Divine*, 72.

⁵⁴ Harlan R. Beckley and Charles M. Swezey, ed., *James M. Gustafson's Theocentric Ethics: Interpretations and Assessments* (Macon, GA: Mercer University Press, 1988).

with my use of materials from the sciences. Nor are they very willing to be open to the responsibility that some contemporary interpretations of how things ultimately are require some change in ethics.⁵⁵

In this article, Gustafson makes it clear that he is committed to an interpretation of ethics within the Judeo-Christian framework of theology. He does so in his Reformed tradition which provides the theological and ideological support for his engagement in a changing ethical landscape. It appears that he is a theologically integrative thinker, one whose self-understanding is that of transformer of culture. In this sense he should probably be located between Paul Ramsey and Stanley Hauerwas. Just as we saw with Ramsey, it seems important for Gustafson to keep his theo-centric rootedness. However, he is much more appreciative of the continuous scientific process than Ramsey was and Hauerwas seems to be. In addition, Gustafson also seems to interpret human activity in God's creative process in a more positive light than Hauerwas. This focus might leave Gustafson with no other position than an inclusivist, revisionist, maybe even a universalist perspective for ethics.⁵⁶ Before we can engage in a constructive discussion on issues in contemporary biomedical ethics with all our representatives, however, we now need to understand the position of Stanley Hauerwas.

4. Stanley Hauerwas

The last of the theological ethicists whom we will investigate here is Stanley Hauerwas. He is probably one of the most prolific writers and most outspoken advocates of character and virtue ethics in Protestant theological ethics in the present era.⁵⁷ It is hard to say which of Hauerwas' monographs is most groundbreaking. He is convinced that "ethics and theology can only be carried out relative to a particular community's conviction".⁵⁸ This conviction sets his academic tone and is different from his colleagues in theological and philosophical ethics who "base the ability to claim our actions as our own in the autonomy of self".⁵⁹ This self, Hauerwas argues, needs to be shaped and formed and moulded by a virtuous community. His early

⁵⁵ Gustafson, James M., "A Response to Critics." JRE 13:185-209, 185-186.

⁵⁶ Cf. Terrence P. Reynolds, "A Conversation worth Having: Hauerwas and Gustafson on Substance in Theological Ethics." JRE 28. 3:395-421, 401-405.

⁵⁷ Cf. Stanley Hauerwas, *The Peaceable Kingdom: A Primer in Christian Ethics* (London: SCM Press, 1983). *A Community of Character* (Notre Dame, IN: University of Notre Dame Press, 1981). *Suffering Presence* (Notre Dame, IN: University of Notre Dame Press, 1986), *Naming the Silence* (Grand Rapids, MI: William Eerdmans Publishing Company, 1990), and with William Willimon, *Resident Aliens* (1991).

⁵⁸ Hauerwas, *A Community of Character*. 2.

⁵⁹ Hauerwas, *A Community of Character*. 262.

thoughts about the formative impact of narrative on 'the individual in community' is put forth in the books *The Peaceable Kingdom, Truthfulness and Tragedy*, and *A Community of Character*. It is in the church community that the individual's character is shaped, where right and wrong are learned, and where "ethics, as the investigation of transforming truth, is at the beginning of theological reflection".⁶⁰ In Hauerwas' understanding, ethics is not about right and wrong; ethics is about the in-breaking of the transforming truth which happens when the community reflects together theologically.

Another thought close to Hauerwas' theological heart is the interpretation of "welcoming the stranger," which is found in his writing on medical ethics.⁶¹ He questions the increasingly compartmentalised art of healing and attributes the paradigm shift in the concept of person to the liberal project. Compartmentalisation allows "modern medicine to see suffering as something that should always be overcome...but who in the zeal to relieve suffering, considers the possibility of removing the sufferer from the scene."⁶² With such consideration he challenges the Christian church to fulfil its potential as the church by being present in the suffering and by welcoming the weak, the stranger, and the handicapped.⁶³ According to Hauerwas, hospitality and being present is a duty Christians ought to practise in light of the hospitable Christ who is present among believers in his resurrection body. In practising hospitality, virtuous agents are forming their ethics in reflection of their theological conviction.⁶⁴ In Hauerwas' conception of a Christian, it might be impossible to divide ethics and theology, for his ethics cannot be had without theology and vice versa.

Hauerwas' adamant rejection of separating theory and practice needs to be understood against the background of his intellectual and theological development. Hauerwas is a product of the modern liberal university in America, the very liberal project he now criticises. As a graduate of Yale University, where he studied under James Gustafson,⁶⁵ Hauerwas was influenced by the critical methods of modern

⁶⁰ Hauerwas, *The Peaceable Kingdom*, 16.

⁶¹ See above, footnote 82.

⁶² Quoted in Verhey and Lammers, *Theological Voices in Medical Ethics*, 70.

⁶³ Cf. Hauerwas, *Suffering Presence*, "Suffering the Retarded: Should we prevent Retardation?" 159-181.

⁶⁴ Hauerwas, *Suffering Presence*, 74-82.

⁶⁵ Jonsen, *The Birth of Bioethics*, 64.

liberal scholarship.⁶⁶ However, by his own admission, his theology became more refined and challenged by many of his teachers, but particularly after his introduction to the writings of John Howard Yoder in the early 1980s.⁶⁷ Several foci in Yoder's writing may have powerfully taken hold of Hauerwas' intellectual and theological conviction.

The most important impact on Hauerwas might be Yoder's insistence on the church's position on peace and non-violence. The peace and non-violence theme is found in all of Hauerwas' writings, but it is probably most eloquently stated in *The Peaceable Kingdom*.⁶⁸ The second Yoderian focus that Hauerwas adapted in this theological work is the necessity of narrative as the formational tool for the individual agent in community. The relationship between narrative, community, and the church's social ethics is best described in Hauerwas' book *A Community of Character*.⁶⁹ From Hauerwas' understanding that the community of believers is the prime locus where the Christian experiences embodiment of the Gospel narrative, another focus of his work evolved, namely, that the Christian churches are a social habitus with a particular ethics. In this argument we find his Aristotelian philosophy best exemplified. By Hauerwas' own admission, this Aristotelian approach sets him apart from other philosophers such as the Platonist Milbank.⁷⁰ In this insistence on narrative theology and community habits as forming agents in the ethics disposition of the believer and his/her community, Hauerwas seems to be influenced by the Aristotelian triangular interconnectedness between *ethos*, *pathos*, and *logos* which are the three important building blocks of rhetoric.⁷¹

Hauerwas' understanding of the social ethics of the church is most directly influenced by Yoder's interpretation of the church as "the pulpit and paradigm".⁷² Embodiment of the Christian gospel and proclamation of the Christian gospel are two sides of the same coin for Yoder, and become increasingly more important in the

⁶⁶ Thiessen Nation, Mark, "Stanley Hauerwas: Where would we be without Him?" in *Faithfulness and Fortitude: In Conversation with the Theological Ethics of Stanley Hauerwas*, by Mark Thiessen Nation and Sam Wells (eds.) Edinburgh: T&T Clark, 2000), 19-36.

⁶⁷ Mark Thiessen Nation, "Stanley Hauerwas: Where would be without Him?" 29-31. There will be an in-depth introduction to John Howard Yoder in Chapter IV and in Chapter V of this dissertation.

⁶⁸ Hauerwas, Stanley, *The Peaceable Kingdom: A Primer in Christian Ethics* (London: SCM Press, 1983).

⁶⁹ Hauerwas, Stanley, *A Community of Character* (Notre Dame, In.: University of Notre Dame Press, 1981).

⁷⁰ Hauerwas, Stanley, "Where would I be without Friends?" in *Faithfulness and Fortitude: In Conversation with the Theological Ethics of Stanley Hauerwas*, by Thiessen Nation Mark and Sam Wells (Edinburgh: T&T Clark, 2000), 323-325.

⁷¹ Aristotle, *Rhetoric I*, 1-35:1356a; *Rhetoric II*, 20:1377b-30:1378a.

⁷² John Howard Yoder, *For the Nations*, 37-50.

authorship of Hauerwas after his introduction to Yoder. In his book *Divine Rhetoric*, Jaroslav Pelikan argues similarly for the inclusion of the three elements of ethos, pathos, and logos in a Christian rhetoric.⁷³ He examines the use of ethos, pathos, and logos in Augustine, Chrysostom, and Luther, three undoubtedly important figures in the history of Protestant theological thought. Ethos depends on the character of the speaker, pathos/persuasion relates to the accurate understanding of the audience, and logos is the message in the speech.

It is not true...that the personal goodness revealed by the speaker contributes nothing to his power of persuasion; on the contrary, his character may almost be called the most effective means of persuasion he possesses...Secondly, persuasion may come through the hearers, when the speech stirs their emotions...Thirdly, persuasion is effected through the speech itself.⁷⁴

The Aristotelian connection between being (ethos), convincing (pathos), and logos (speech) are unmistakably visible in Hauerwas' scholarship. Who we are as people, or as communities is experienced by others through the things we say and by the way we say it. Pelikan calls this inextricable inter-relatedness of being, convincing, and speaking as "the proofs or means of persuasion" for the congruency of the person's being and speaking.⁷⁵ Since Hauerwas is trained in Classics, we could assume that he is aware of these inter-related steps of rhetoric, and it is quite obvious in his scholarship that he knows how to use them as well. We will see in Chapter IV and V of this dissertation how much influence John Howard Yoder had on Stanley Hauerwas' theological ethics, but it will suffice here to mention him as one of the very influential and outspoken theological ethicists in the development of biomedical ethics.

II. PHILOSOPHICAL APPROACHES IN BIOMEDICAL ETHICS

We now need to introduce briefly philosophical theories in biomedical ethics. An introduction is provided through discussing the far-reaching influence of one of bioethics most frequently cited books, *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress.⁷⁶ Tom Beauchamp is a philosopher and James Childress a religious studies scholar who attempted to provide insights about "how ethical theory can illuminate problems in health care and help overcome some

⁷³ Pelikan, Jaroslav, *Divine Rhetoric: The Sermon on the Mount as Message and as Model in Augustine, Chrysostom, and Luther*. (Crestwood, NY: St Vladimir's Seminary Pres, 2001). 151-155.

⁷⁴ Aristotle, *Rhetoric I*, 1-15:1356a.

⁷⁵ Pelikan, *Divine Rhetoric*, 98.

⁷⁶ Beauchamp and Childress, *Principles of Biomedical Ethics*, 1994⁴).

limitations of past formulations of ethical responsibility".⁷⁷ It can undoubtedly be stated that they have reached their objective, since their book is in its fifth edition within 24 years. The book seems to be a permanent fixture in many bioethics courses, introducing students to the principles of autonomy, nonmaleficence, beneficence, and justice.⁷⁸

Beauchamp and Childress' comprehensive introduction to philosophical principles have been constructed on the basis of their background in religious studies and philosophy. The strong focus on four distinct principles that can be used in a variety of cases in different settings has often been criticised or elaborated on. In an article called *The Principles of the Belmont Report Revisited*, Eric Cassell, for instance, paints an interesting picture of the use of autonomy, beneficence, and justice from the principles' first inception in the Belmont Report for the National Commission for the Protection of Human Subjects and its use today.⁷⁹ He argues that the focus of the principles has shifted from a holistic view of the healing of the entire person to a segmented view in favour of the cure of body parts.⁸⁰ There is no doubt that a hyperfocus on principles alone could support a compartmentalised view of the patient, but it is doubtful whether one can lay all the blame for such a development on one report or one text book. As Baroness Onora O'Neill rightly questioned in her recent article *Practical Principles and Practical Judgement*, "whether principles are intrinsically inadequate or morally suspect or [whether] they are an essential component of ethical reasoning and deliberations" needs to be repeatedly considered.⁸¹ Beauchamp and Childress have unquestionably done a great service to the field of bioethics by their painstaking research and the consequent introduction of the *Principles of Biomedical Ethics*, thus situating the book close to the intersection between theology and philosophy.

At the beginning of the book Beauchamp and Childress take pains to reason about different ethical approaches. They distinguish clearly between moral theology, theological ethics, and religious ethics, which all belong to the field of theological and religious traditions on one hand; however, and on the other hand, between they distinguish between ethical theory, moral philosophy, and philosophical ethics, which they say "are reserved for philosophical theories and reflections of common

⁷⁷ Beauchamp and Childress, *Principles of Biomedical Ethics*, 3.

⁷⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, Chapters 3-6.

⁷⁹ Cassell, Eric J. "The Principles of the Belmont Report Revisited," HCR, 30:4, 2000. 12-21.

⁸⁰ Cassell, "The Principles of the Belmont Report Revisited," HCR, 30:4, 2000, 21.

⁸¹ O'Neill, Onora, "Practical Principles & Practical Judgements," HCR, 31:4, July/August 2001, 15-23.

morality”.⁸² In addition, they view professional ethics as “codes that specify rules of etiquette and responsibilities”.⁸³ Even though it is a noble cause to distinguish high levels of ethical reasoning, several tentative questions come to mind about such divisions. Is an agent not often part of several competing ethical theories, particularly in the field of biomedicine? If this is indeed the case, which ethical theory would take preference in difficult decisions? In addition, are philosophical ethics and theological ethics as easily dividable when one considers the tremendous influence of ancient Hellenistic philosophy on the development of Christian theology? Can philosophy really be separated from theology when one uncovers the influence of Aristotle on the reasoning of Augustine, Aquinas and Luther? How does an agent decide when competing ethical theories beg for equal attention? And one last question that is the basis for this chapters’ inquiry, can ethical reasoning in biomedical ethics really be divided between a principlist approach and a virtue ethics approach?

These are a few preliminary questions that need to be asked at the beginning of this dissertation, particularly at the introduction of such an important text as the *Principles of Biomedical Ethics*. The remainder of this dissertation will try to answer these questions in various chapters from several different angles. However as influential the introduction of autonomy, beneficence, nonmaleficence, and justice have been to the field of biomedical ethics, they are still ‘only’ principles which need embodiment by individual agents – or groups of agents - in the every day medical setting. To that end, the principle lacked one vital factor, namely the important focus of the agent’s embodying implementation of the above mentioned principles. Onora O’Neill calls this the necessary translation of principles into practical judgment.⁸⁴ Notwithstanding these observations, Beauchamp and Childress’ fine scholarly contribution included the various philosophical approaches to ethics, two of which will be the focus of the remainder of this Chapter.

A) The Principlist Approach defined

When the term principlist approach is used in this dissertation, and particularly in this chapter and in the concluding chapter, it refers to Beauchamp and Childress’ four principles of autonomy, beneficence, non-maleficence, and justice.

⁸² Beauchamp and Childress, *Principles of Biomedical Ethics*, 5-6.

⁸³ Beauchamp and Childress, *Principles of Biomedical Ethics*, 7.

⁸⁴ O’Neill, “Practical Principles & Practical Judgements,” 22

Autonomy is defined holistically which includes the understanding that only a autonomous person can also make autonomous choices. "Autonomous actions should not be subjected to controlling constraints by others, [rather] we must respect individuals' views and rights so long as their thoughts and actions do not seriously harm other persons."⁸⁵ The principle of *nonmaleficence* requires the obligation not to harm the patient, an obligation that leans closely to the medical ethics requirement *primum non nocere*.⁸⁶ *Beneficence*, on the other hand, is interpreted by Beauchamp and Childress as a principles that requires provisions of benefits. "Morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contributes to the welfare of the patient."⁸⁷ The last of these principles is the most difficult to define, according to Beauchamp and Childress. It is the principle of *justice*, which is divided and distinguished as *distributive justice*, *rectificatory justice*, and *social justice*. Distributive justice refers to "fair, equitable and appropriate distribution", social justice to the allocation of resources, and rectificatory justice to the "just compensation for transactional problems such as breaches of contracts and malpractice".⁸⁸ This short introduction to the principles shall suffice here as the basis of the term principlist approaches in biomedical ethics. The religious studies scholar Albert Jonson criticises a principlist approach from a different angle than Clouser and Gert, pointing to the difficulty of ethical decision-making that lies between principlism and casuistry.⁸⁹

The principles have been criticised repeatedly for being "little more than checklists, lack of systematic order and coherence, and for being too indeterminate in decision procedures", most notably by the philosophers K. Danner Clouser and Bernhard Gert.⁹⁰ Their main critique is not only with the content of the principles, but also with their uses. As for content critique, Clouser and Gert challenge Beauchamp and Childress to have not given adequate reference to the moral theories that are embodied in the principles.

⁸⁵ Beauchamp and Childress, *Principles of Biomedical Ethics*, 126.

⁸⁶ Beauchamp and Childress, *Principles of Biomedical Ethics*, 189.

⁸⁷ Beauchamp and Childress, *Principles of Biomedical Ethics*, 259.

⁸⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, 327.

⁸⁹ Albert Jonson, "Of Ballons and Bycycles or the Relationship between Ethical Theory and Practical Judgement," HCR 21: 14-16, Sept – Oct. 1991.

⁹⁰ Cf. K. Danner Clouser and Bernhard Gert. "A Critique on Principlism," *The Journal of Medicine and Philosophy* 15:23, April 1990. 220. Albert R. Jonson and Stephen Toulmin. *The Abuse of Casuistry*. (Berkeley, CA: University of California Press, 1988).

Using principles in effect as surrogates for theories seems to use to be an unwitting effort to cling to four main types of ethical theory: beneficence incorporates Mill; autonomy, Kant; justice, Rawls; and nonmaleficence, Gert. Presenting the matter as so many principles suggests that the principles have been integrated into one unified theory, whereas the exact opposite is true. The four main theories are reduced to four principles from which agents are told to pick and choose as they see fit, as if one could sometimes be a Kantian and sometimes and Utilitarian and sometimes else, without worrying whether the theory one is using is adequate or not.⁹¹

This is a serious critique on the principlist approach, and in it is exactly in this critique where the necessity of the virtuous agent arises. Defining the principles and the basis of their moral theories lies in the responsibility of the individual agent or group of agents. The definition of the principles is often done under the pressures of the clinical setting, where time is of essence. Virtue ethics and the individual agent is the crucial connector at the intersection between principles and their use in the clinical setting. The individual agent (physician, nurse, ethicists, philosopher, etc.) goes through character formation in his/her development. In this development lies the preparation of the agent to be able to discern and define the appropriate principles in a given case. Moreover, in the process of virtue learning and character development, the individual agent has learned the moral theories behind the principles as well, and is therefore prepared to deal with the tension between principles and moral theory. Through the interview excerpts we will see that the Anabaptist/Mennonite physicians seem to be at exactly this intersection between how one interprets principles of biomedical ethics in everyday medical practice. However, before we can proceed with the discussion between principlist approaches to contemporary biomedical ethics and virtue approaches, we now need to define the term virtue ethics as it is used in the body of this dissertation, and particularly in the following discussion between these two approaches.

B) Virtue Ethics defined

Another important, and for the thesis of this dissertation very prevalent ethic we need to consider here is *Character or Virtue Ethics*, which emphasises the agent(s) who perform(s) actions and make(s) choices. “Based on Plato and Aristotle,

⁹¹ Clouser and Gert, “A Critique on Principlism”, 223.

character ethics assigns virtuous character a pre-eminent position".⁹² Through numerous writings of Stanley Hauerwas⁹³ and William May,⁹⁴ and to some extent through publications of Alasdair MacIntyre, this ethic has become an acceptable philosophical theory in biomedical ethics over the last decade.⁹⁵ The philosophy of virtue ethics also finds wide application in religious studies and theology, and one wonders whether this might be the place where theology and philosophy overlap sufficiently to satisfy the intellectual framework for both disciplines. This particular question is the theme of a book called *The Christian Case for Virtue Ethics* by Joseph Kotva.⁹⁶ Kotva claims that "the virtue framework is especially well-suited for voicing Christian convictions about the moral life".⁹⁷

Virtue ethics can be traced back to Plato who considered "courage, temperance, wisdom, and justice to be the cardinal virtues...that perfect various aspects of the soul".⁹⁸ Aristotle, however, claims that those cardinal virtues are not just somehow present in a person: "neither by nature, then, nor contrary to nature do the virtues arise in us; rather we are adapted by nature to receive them, and are made perfect by habit".⁹⁹ In continuity with Plato, who only stated what kind of virtues are present in a person, Aristotle insists that virtues are formed by habits, by how we live and by the things we choose to do, "for the things we have to learn before we can do them, we learn by doing them".¹⁰⁰ Aristotle also distinguishes between intellectual virtues and moral virtues. Intellectual virtues owe their birth and development to teaching, whereas "moral virtues are a result of habit, from Greek *ethike*, which is derived from *etho*~, habit" according to Aristotle.¹⁰¹ The extension of Plato's discovery that the virtues are there to Aristotle's focus on exercising those virtues is a major focus for this dissertation as well.

⁹² Beauchamp and Childress, *Principles of Biomedical Ethics*. 62.

⁹³ Hauerwas, *A Community of Character. Suffering Presence. Naming the Silence*. With William H. Willimon Hauerwas, *Where Resident Aliens Live: Exercises for Christian Practice* (Nashville, TN: Abingdon Press, 1996).

⁹⁴ William F. May, *The Physicians Covenant: Images of the Healer in Medical Ethics* (Philadelphia: Westminster Press, 1983). *The Patient's Ordeal*, ed. David H. Smith and Robert M. Veatch, *Medical Ethics Series* (Bloomington: Indiana University Press, 1991). *Testing the Medical Covenant* (Grand Rapids: Eerdmans Publishing Company, 1996).

⁹⁵ Cf. Alastair MacIntyre, *After Virtue: A Study in Moral Theory*, (Notre Dame, IN/London: University Press/Duckworth, 1984²).

⁹⁶ Joseph Kotva, J. Jr., *The Christian Case for Virtue Ethics*, by James F. Keenan, S. J. (ed). *Moral Traditions & Moral Arguments* (Washington, D. C. Georgetown University Press, 1996).

⁹⁷ Kotva, *The Christian Case for Virtue Ethics*. 16.

⁹⁸ Plato, *The Republic*, (New York/Oxford: 1964). 119-144.

⁹⁹ Aristotle, *Nicomachean Ethics*, 23-25:1103a.

¹⁰⁰ Aristotle, *Nicomachean Ethics*, 30:1103a.

¹⁰¹ Aristotle, *Nicomachean Ethics*, 15-20:1103a.

We often speak of the ethos of a culture, an era, or a community. Ethics seems to be informed by the ethos of a certain era, culture, or community. The ethos of Luther's Reformation was to give religious independence to the people and let their conscience be the judge of their spiritual, ethical and moral behaviour. The ethos of the Enlightenment was to free religion from the sentimentality of piety. And the ethos of modernity was to give prosperity and independence to the individual without the interference of religious, social, or economic restrictions. The ethos of post-modernity is to question everything, to question normative behaviour, and, as Miroslav Volf criticises

...to think of the future only in terms of extrapolations from the trends today. It is scandalous to think of the future only in terms of extrapolations [of the present]. For me as a Christian theologian, a way to think about life after death is also a way to think about a normative future for our world and for our situation, and a normative future that is promised to us by God.¹⁰²

Even though Volf does not do research in the particular field of biomedical ethics, his observations seem very useful for questions in this field. Most scientific advances in biomedical ethics today are so groundbreakingly new, such as most the results and future possibilities of the Human Genome Project, that we cannot refer back to any historical precedence cases. If there is no such historical precedence, how do we decide what is ethically justifiable behaviour in the present? What kind of importance does ethics have in our quest to find answers in medical decision-making? Moreover, how will our decision-making today influence the future of biomedical ethics, once our present time and our present quandaries become historical precedence? For instance, is it advisable, or even responsible, to let health care of a particular country be dictated solely by its economic viability with little regard for those agents who are unable to be part of such an economically based health care system? How can we ensure that principles in biomedical ethics are implemented according to the best intentions of those who established the principles? Is there not a crucial place between principles and practice where the question of the acting agent needs to be addressed?

Do character and virtue, utility and deontology have any influence in the formation of an individual agent, and how will that influence manifest itself in a given health care system? If, as we have seen in this chapter, theories of ethics abound, how does one make decisions in biomedical ethics that are true to oneself and one's convictions?

¹⁰² Volf, Miroslav. "Conversations", Conrad Grebel Review 18:81. 3/2000.

1. Christian Virtue Ethics defined for this Dissertation

In this dissertation, virtue ethics will become the main point focal point in the construction of an Anabaptist/Mennonite approach to biomedical ethics. In this dissertation, virtue ethics will be defined in three distinct stages, a) who we are; b) who we could be; and c), the process by which we get from the former to the latter. This teleological concept of virtue ethics is based on Joseph Kotva's interpretation of Aristotelian virtue ethics, and seems to support this dissertation best by "encouraging and [or] discouraging certain kinds of actions, habits, capacities and inclinations because they direct us toward or away from our true nature or end".¹⁰³ Kotva not only stresses the need for virtue ethics because it helps us to focus on the agents and their context as the persons who will embody principles or solve quandaries,¹⁰⁴ he also stresses a *Christian* case for virtue ethics. Very carefully, he tries to relate virtue ethics to Christianity, using three distinctly Christian concepts to show how virtue ethics could complement those concepts.

Kotva's first concept is sanctification, which he also calls "personal or individual eschatology".¹⁰⁵ The teleology of sanctification is understood as a process of transformation of one's character through the development of certain virtues. This process lasts a lifetime and has the telos to transform a Christian more and more into the image of Christ. The entry point into this process is conversion and repentance, and the energy for this process is God's active grace in human life. Human action is a faithful response to God's grace, "it is a life that involves our growth in righteousness, but it is also a life founded on God's initiative of choosing, accepting, and forgiving us. Growth continues throughout one's life, but growth is possible only because of divine grace".¹⁰⁶

Closely related to the concept of sanctification is Kotva's second emphasis on Christian virtue ethics, namely Christology. The importance of Christology is strongly dependent on Christ's human life as the example that we are called to imitate. From this imitation of Christ flows discipleship, where the disciple takes key concepts of the master and embodies them in his/her own life. Not only that, the disciple will also take the master's life as an example of who he/she wants to be like, whom he/she wants to model their own life after. In this last point we find a strong

¹⁰³ Kotva, *The Christian Case for Virtue Ethics*. 20. See also Alistair MacIntyre's *After Virtue*, and Stanley Hauerwas and Charles Pinches' *Christian among the Virtues: Theological Conversations with Ancient and Modern Ethics*. (Notre Dame, IN: University of Notre Dame Press, 1997).

¹⁰⁴ Kotva, *The Christian Case for Virtue Ethics*. 12.

¹⁰⁵ Kotva, *The Christian Case for Virtue Ethics*. 69.

¹⁰⁶ Kotva, *The Christian Case for Virtue Ethics*. 75.

correlation with Aristotle's emphasis on the apprentice-master relationship, in which the apprentice receives moral education and support from his/her master for the practice of virtues. The Christological aspect of Kotva's Christian virtue ethics means that

Christ is not simply the giver of rules and principles, but humanity's goal. In Jesus, we see not only the acts we are to perform or the rules we are to follow. In Jesus we see the kind of people we are to become, the kind of humanity we are to embody.¹⁰⁷

The last of Kotva's emphases for a Christian virtue ethics comes out of his understanding of Christian anthropology. Here he sees two potentially cogent links between virtue theory and Christian theology. First, there is the understanding that we as humans are a combination of limitations and freedom. We are limited by finitude and by sin. However limited, we are also free to choose and determine our fate - albeit within the redeemed, but still limiting features of finitude and sin. Kotva sees this Christian understanding of anthropology as closely related to virtue theory's understanding that we are "neither completely determined not completely free".¹⁰⁸ The second link between virtue theory and Christian theology seems to revolve around the theme of our communal nature. Christian anthropology clearly does not see us as individuals only but stresses the Bible's emphasis on our communal nature. Likewise does virtue theory, where community is the most necessary locus for the formation of the individual. As persons we live with the tension of 'redeemed freedom and limitation' and could be subject to extreme polarisation between total freedom and total determinism. In Kotva's view, what keeps us from wildly swinging between those two extremes is the constancy of the believing community with its reminder of baptism, Eucharist, and worship.¹⁰⁹

Sanctification, discipleship, and community are the pillars that Kotva sees as most prominent features in the development of a Christian virtue ethics and its subsequent use in the formation of the virtuous agent. How such a Christian virtue ethics is used in Anabaptist/Mennonite theology and ethics will become increasingly evident as we progress through the various chapters of this dissertation. In the interview analysis in Chapter III we will find similar expressions of Christian virtue ethics to those described by Kotva, but they will be in the words of the Anabaptist physicians. In Chapter IV on Anabaptist theology and ethics, we will find

¹⁰⁷ Kotva, *The Christian Case for Virtue Ethics*. 88.

¹⁰⁸ Kotva, *The Christian Case for Virtue Ethics*. 91.

¹⁰⁹ Kotva, *The Christian Case for Virtue Ethics*, 107-110.

resemblance to, and connections with, the previously described understanding of Christian virtue ethics. And finally, in Chapter V and the discussion of John Howard Yoder's scholarship on the themes of the empirical study, we will again find common threads of Christian virtue ethics.

III. PRINCIPLISM AND VIRTUE ETHICS

The discussion between the principlist approach and a virtue ethics approach as discussed here revolves around several distinct areas of discussion. First, we have to start with a necessary, but brief historical discussion about the reasons why contemporary biomedical ethics has now at its centre a discussion of the relationship between a principlist and a virtue approach. Secondly we then need to show what kinds of other approaches there can be found to biomedical ethics, such as a casuistry approach or a post-modern approach as an 'ethics from nothing' approach. This approach to biomedical ethics, the post-modern view of, will also be the only example we can use in this restricted space, to discuss non-religious approaches to biomedical ethics. The last discussion we can engage in is based on the question to what extent do principles need individual agents? Is a principle a principle if it is not used by anyone? What is the correlation between a principle - which had to be established by individuals, or groups of individuals, to become a principle per se - and the individual virtuous agent?

1. Principlists in their developmental context

Beauchamp and Childress' *Principles of Biomedical Ethics* are to a large part an extension of the historical *Belmont Report* of 1979. This document was the initial discussion paper commissioned by the 'National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1974-1978'.¹¹⁰ The mandate from the commission was to "identify the ethical principles which should underlie the conduct of biomedical and behavioural research with human subjects and develop guidelines that should be followed in such research".¹¹¹ In close reading of the Nuremberg Code of 1947 and the Declaration of Helsinki 1962, the commission established three main principles, namely beneficence, freedom, and justice. The final paper of the commission, one of whose member was James Childress, was subsequently known as the *Belmont Report*.¹¹² The three established

¹¹⁰ Jonson, *The Birth of Bioethics*, 99.

¹¹¹ Jonson, *The Birth of Bioethics*, 102.

¹¹² Jonson, *The Birth of Bioethics*, 103ff.

principles were intended for use in human subject research, but seem to have found widespread application in the fast growing field of bioethics. Coincidentally, the first edition of *Principles of Biomedical Ethics* was published in 1979 by Oxford University Press, the same year of the final approval of the *Belmont Report*. It remains the work of another researcher to establish connections with, and the impact of the *Belmont Report* on Beauchamp and Childress' *Principles*.

For our discussion here it is important to note however, that the principlist approach to contemporary biomedical ethics has a long history. Establishing adequate principles that can be used in a variety of cases and settings, was based on several issues. There was first the historical precedence of the cruelty of medical research on human subjects by Nazi doctors. To prevent such cruelty from being repeated, guidelines and principles needed to be established to which all of medical research had to submit to. Secondly, the second issue of the process of establishing the principles was the exact definition to prevent misuse again, but also to provide enough flexibility so that the principles can be applied in a variety of circumstance and cases. The last issues could arise to be the most difficult aspect in the establishment of the principles. In addition to the exact definition that guarantees a maximum of flexibility, the principles also have to be so inclusive that they can be used in public policy making. In a vast country like the USA, such public policy principles need to be almost endlessly interpretable. Even in the initial discussions of the *Belmont Report* this last point appeared to be the biggest hurdle, when Commissioner Brady objected that the working group selected "too many principles...and some of them are not universal."¹¹³ It seems however, that Beauchamp and Childress book *Principles* was able to deal with all these problematic points in the development of a principled approach to biomedical ethics.

In this brief review we can see that it is not possible to understand the need, as well as the problems in the development of principles. Most academic work, but especially academic work in contemporary biomedical ethics needs to be acutely aware of its historical contingency. The principlist approach to biomedical ethics needs to pay particular attention to its historical contingency, but it also needs to be aware of the necessity to allow enough flexibility for principles to be applied in variety of circumstances.

¹¹³ Jonson, *The Birth of Bioethics*, 103.

2. Principlists and Casuists

Before we can approach the discussion between principlists and virtue ethicists, we briefly need to discuss some selected alternative approaches to biomedical ethics. Those alternative approaches are also called non-religious, but in the context of this dissertation we need to be clear that any school of thought includes proponents of any or no-religious conviction. We therefore chose the term 'alternative' as opposed to 'non-religious', as the former appears less discriminatory.

An early proponent of casuistry seems to be Joseph Fletcher with his emphasis on the right of the patient.¹¹⁴ Albert Jonson and Stephen Toulmin co-authored another publication called *The Abuse of Casuistry. A History of Moral Reasoning*.¹¹⁵ The problem casuistry has/had with principlist in biomedical ethics, is that the principlist approach seems to generalising ethical and philosophical principles, whereas biomedical ethics in general, but early bioethics in particular, struggled with such theoretical principles in day-to-day applications of cases. Principlists need to take this charge seriously, for it will be evident in the main part section of this dissertation that the Anabaptist/Mennonite physicians do have similar questions for the principlists. Casuistry, on the other hand, has to acknowledge likewise that in an academic field such as biomedical ethics, principles might have a necessary unifying function in ethical decision-making. Casuists need to see the need for governing principles, but they also need to understand themselves as vital parts that challenge, improve, and if necessary, re-direct the use of certain principles. It is necessary that principlists and casuists understand the need for mutual dependency on, and responsibility for each other, because it could be that in a mature relationship of both these school of thoughts that biomedical ethics will gain its greatest strength. Casuists seem to challenge increasingly a principlist approach to biomedical ethics on the basis of the number of variables that need considerations that are case specific; therefore it is impossible to have principles that are obligatory in each and every case.

Even though we do not have the space here for an extensive discussion, we nonetheless need to mention another, rather recent development in ethics and biomedical ethics. This is the post-modern approach to ethical and moral reasoning

¹¹⁴ Fletcher, Joseph. *Morals and Medicine. The moral Problem of: the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilisation, and Euthanasia*. (Princeton, NJ: Princeton University Press, 1954).

¹¹⁵ Cf. Jonson, and Toulmin. *The Abuse of Casuistry*.

that attempts to start with 'the view from nowhere'.¹¹⁶ The proponents of this approach try to reason on the basis of non-foundationalism, non-principlism, and non-historicism. Laurie Zoloth criticises this view as "lacking objective standards...but with a range of moral sensibilities".¹¹⁷ It will be the work of another dissertation to explicate the influence of post-modern ethics on contemporary biomedical ethics, but we will need to heed the earlier warning of Miroslav Volf that it could prove potentially devastating to biomedical ethics if we understand the future only as extrapolation of the present.¹¹⁸ This seems to be a particular frightening prospect for biomedical ethics and its related biosciences and biotechnology with their potentially groundbreaking discoveries.

3. Principlists and agent based Virtue Ethicists

The place of principlism

As indicated above, agent based virtue ethics places moral decision-making under the auspice of the individual agent, or as in the case of Christian virtue ethics, under the auspice of the individual agent as part of the believing community. Virtue ethicists seem to have a tendency to feel more accepted intellectually in community settings. In such a community setting the tendency for moral discourse seems to pay equal respect for the inter-relationships among the community members, as it respects the need for principles in the discourse. It would be academically short-sighted to claim that communities do not have principles which they follow, or, on the other hand, that principles do not need to be interpreted in a variety of intellectual and religious settings of moral reasoning. We therefore now need to discuss two important issues that seem to be notoriously overlooked in the discussion between principlists and agent based virtue ethicists. Notable exceptions in this polarised discussion is the discourse in feminist bioethics, as the recent article "Understanding Autonomy Relationally: Towards a Reconfiguration of Bioethics Principles" by Anne Donchin shows.¹¹⁹ Feminist bioethics seems to understand the need for relational aspects in contemporary biomedical ethics discourse instinctively better,

¹¹⁶ For a good introduction to post-modern moral reasoning see "Modern Morals in Postmodernity: A Critical Reflection on Professional Codes of Ethics" by Toon van Meijl in *Cultural Dynamics*, Mar 2000, Vol. 12 Issue 1:65-82. Cf. Ross Abbinnett, "Postmodernity and the Ethics of Care: Situating Bauman's Social Theory", *Cultural Values*, Jan 98, Vol. 2 Issue 1: 87-117. Zygmunt Bauman, *Postmodern Ethics*. (London: Blackwell Publishers, 1993).

¹¹⁷ Zoloth, Laurie and Susan B. Rubin. "Dead Wrong: Error in Clinical Ethics Consultations." In *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth, 195-216. Hagerstown, MD: University Publishing Group, 2000. 199.

¹¹⁸ Cf. note 93 above.

¹¹⁹ Donchin, Anne, "Understanding Autonomy Relationally: Towards a Reconfiguration of Bioethics Principles", *JMP* 26:365-386, Vol. 4 August 2001.

thereby offering a re-interpretation of principles without falling prey to more polarisation.¹²⁰ The discussion that follows is best stated in a question. Which contributing factors make a principle a principle and what place does the individual agent/group of agents have in this process?

Beginning with the first part of the question – when is the principle a principle – we need to refer back to the historical discussion above. Had the National Commission for the Protection of Human Subject not commissioned a rather large group of philosophers, theologians, and ethicists to establish “ethical principles which should underlie the conduct of biomedical and behavioural research” then there would not have been a *Belmont Report* and subsequent a book.¹²¹ Alternately, if the group of academics were constituted by different members, and if there had been different mandate for that group, we might have different principles. We cannot discuss all possible resulting principles that are resulted on a contingency of the group and on the nature of the mandate. The point is that principles are established by individuals/group of individuals and the written into legislation. But even all that processing does not make a principle a principle, its still just only words on a piece of paper.

We need to be aware of the fact that a principle only then becomes a principle when a person and/or group of persons actually adhere to the principle. If the principle is not practically applied, it is de facto a principle but give little meaning. It is only when the individual/group of individuals apply the principle that the principle has meaning and makes a contribution. Thus the principle needs the individual agent to give the principle meaning and apply it. Moreover, we need to be aware of the historical contingency of principles, particularly the historical predecessors that gave rise to them, such as the Nuremberg Code and the Helsinki Declaration. Principles of public policy and laws are never made and/or changed without paying close attention to the previous documents. Therefore, we need to be particularly clear about the fact that the *Belmont Report* and the *Principles* were based a) on previously important documents that guided research in the past, b) written as a response to pressing questions of a particular era of research with various sets of particular sub-questions, and c), that principles need to be able to adapt to changing situations in the present and the future, lest the principles cease to be principles.

¹²⁰ Cf. Purdy, Laura, M. *Reproducing Persons: Issues in Feminist Bioethics*. (Ithaca, NY: Cornell University Press. 1996). See also the discussion of Lisa Cahill and Laurie Zoloth, p. 5-11 above.

¹²¹ Jonson, *The Birth of Bioethics*, 333.

Thus we have to answer our question above and state that the contributing factors that make a principle what it is, are first, its useability, and secondly, its adaptability to historical change. As stated in the previous point, principlists also need to be aware that individuals and groups of individuals are needed to induce principles with life. Hence, principles come to life and useful meaning only by adapting them after meaningful moral discourse about them.

The second part of the above question, what place does the individual have in the principles' application, can be answered briefly. The moral discourse of individuals and groups of individuals about the principle is the place where the principle is given meaning, and hopefully, finds subsequent use in the life of the individual and the community. This argument is most clearly stated in "A Critique to Principlism" by the late K. Danner Clouser and Bernhard Gert.¹²² Both these philosophers are far from being virtue ethicists or casuists, but they unmistakably point out the critical issues of unreflected principlism.¹²³ The principles need to be applicable to individual cases *after* moral discourse, and it is in this moral discourse where the individual virtuous agent plays a crucial role.

The role of the moral agent

In current biomedical ethics discourse we find a strong emphasis of virtue ethicists on moral agency and the interpretative community. Unfortunately, virtuous moral agency is often juxtaposed as incompatible with a principlist approach. This must not be the case if either party could understand that they need each others' approach for successful at discourse in contemporary biomedical ethics. We have already seen above, that principles can only be principles when the interpretive agent is able to use the principles. What then is the role and responsibility of the moral agent in the discourse? To answer this question we need to go back to Danner Clouser and Gert's critique on the principlists approach.

An adequate ethical theory should not be just some more or less systematically related set of principles and rules. Rather it should provide an explanation of our moral agreement and disagreement; it should organize our moral thinking; it should tell us what is relevant to a moral judgement. In formulating theory we start with particular moral judgement about which we are certain and we abstract and formulate the relevant feature of those cases to help us in turn to decide the unclear cases.¹²⁴

¹²² Clouser Danner K and Bernhard Gert, "A Critique on Principlism", JMP 15:219-236, Vol. 2, April 1990.

¹²³ Clouser and Gert, "A Critique on Principlism", 235.

¹²⁴ Clouser and Gert, "A Critique on Principlism", 232.

The most distinct difference between principlists and virtue ethicists is encompassed in the sentence “[i]n formulating theory we start with particular moral judgement about which we are certain”. In this phrase Danner Clouser and Gert have located their most serious critique on principlist approaches. And it is also in this phrase that principlists and virtue ethicists part in their methodological approaches. Where the principlist begins with established universal principles that are applicable to everyone in most situations, the virtue ethicists begins with particular moral judgment and enlarges this into an ethical or moral theory. But these difference of approaches does not exclude the possibility that both parties can arrive as similar results. We will see in the remainder of this dissertation that the latter approach to biomedical ethics is what the Anabaptist/Mennonite physicians seem to practise. Their particular moral judgement is based on Anabaptist peace theology that denounces violence and instead focuses on reconciliation and justice. It is imperative to be very clear about the fact that there are differences between virtue ethicists, and not nor everyone of this school uses the same approach. Likewise with principlists, not every principlist is the same and distinctions have to be made. However, for the space we have available in this chapter, a generalised idea of the two approaches has to suffice.

The virtue ethics approach that this dissertation will use throughout is a Christian virtue ethics, is a Christian virtue ethics grounded in Anabaptist/Mennonite theology. There are other religious approaches to virtue ethics, and in the context of those religions, each has its merit when it is able to make specific contributions to contemporary biomedical ethics. An Anabaptist virtue ethics displays the following features, which are vital aspects in the formulation of an adequate ethical theory. Firstly, there seems to be an exemplary process of virtue development within the theological structure. Virtue development and the agent’s character formation happen within the safe environment of the church community. Such character formation then goes through a process of owning, when the individual agent makes decision about his/her own use of Christian virtue ethics. Secondly, there is the vital place of the community, which is needed for the moral discourse about particular ethical (and theological) theories. The most vital contribution of the Christian community to its

individual moral agents is to provide a place of discourse, and that discourse in turn could sharpen and clarify the ethical and moral conviction of the community.¹²⁵ The moral discourse occurs in reflection of particular Christian worship and rituals such as baptism, the Eucharist. These signs of Christian tradition are where “particular moral judgement evolves” and from which relevant features have to be abstracted to contribute to biomedical ethics.

The contributions that virtue ethicists bring to the conversation with principlists is the formation of moral agency which in turn needs to interpret and discuss the principles as advanced by the principlists. Principlists and virtue ethics approaches are mutually dependent, and it is only in conversation with each other that mutual respect is built and sensible contributions towards the solution of ethical problems can be made.

Virtue Ethics and Mennonite Physicians

As we will discover in the remaining chapters of this dissertation, virtue ethics seems to be the choice for the Anabaptist/Mennonite physicians in this study. In an interestingly unconscious way, the physicians in this study do not state any theoretical or empirical way of practising virtue ethics. Virtue ethics appears to be more like an embodied reflex with which they practise their physician’s art. Moreover, it seems that virtue ethics could even be described as the motivation for their initial entry into this professional career. Although most of the physicians would be hard pressed to verbalise the philosophical theory of ethics behind their medical involvement, it seems that they do not have nearly as much difficulty in the theological defence of the ethical positions they use in medicine. This discovery leads us to seek out the connection between theology and ethics, particularly between Anabaptist/Mennonite theology and ethics.

Radical Reformation theology and ethics does not seem to have had any serious affect on the historical development of biomedical ethics in the USA in recent history. In addition to the rather subconscious practice of virtue ethics, we find another important factor in the practice of the Mennonite physicians. All of the volunteers put heavy emphasis on their community involvement and the impossibility for the individual ‘to do it all alone’. This becomes particularly evident when we realise that all of the physicians mention a process which is similar to the

¹²⁵ This is a dissertation about Christian approaches to virtue ethics, we therefore have not enough space available to discuss non-Christian, or even non-religious approaches.

participant observation model in their formative years. Mentors, returning missionary physicians, growing up in a medical missionary setting, college professors, and a number of other personal influences moulded and shaped the physicians while they were growing up and made decisions about their professional careers. Besides virtue ethics, community involvement and support has been the second determinative factor for the physician's choice of career and for their continuous involvement in the medical field.

These observations will lead us to research questions that will guide us through this dissertation: what is the basis for the Mennonite physician's ethical conviction, where is the source of that conviction, how has the conviction developed, and what are the embodied manifestations of such convictions today? By trying to discover answers to these questions in the dissertation, we will find supportive arguments for the thesis that this dissertation advances, namely that *it is in the theology and ethics of Anabaptism that we find unique contributions to questions of contemporary biomedical ethics*. As we have seen throughout this chapter, Anabaptist/Mennonite virtue ethics has not been an active contributor to the development of biomedical ethics in the same way that the principlist approach to biomedical ethics has been. It is beyond the scope of this work to provide detailed reasoning as to why this was the case, but it is the main aim of this dissertation to show that in the Anabaptist/Mennonite theological and ethical approach to biomedical ethics there are constructive contributions to our current questions in biomedical ethics which have not been adequately taken into consideration.

Concluding reflections

This chapter has set the stage for the discussion of the argument of this dissertation, namely that Anabaptist/Mennonite theology and ethics have an important contribution to make to the contemporary discussion in biomedical ethics. We have been introduced to four distinguished contemporary scholars in the field, all four of whom come from distinctly different religious backgrounds. The reason to choose such a wide variety of scholars has been done to give an impression on just how diverse the contemporary discussion in biomedical ethics is today.

In the second part of this chapter we have then been introduced to two specific approaches to biomedical ethics today. There is firstly the principlist approach which is based on the methodology of Tom Beauchamp and James Childress' book *Principles of Biomedical Ethics*. Secondly, we were then introduced

to a virtue ethics approach, but more specifically, a Christian virtue ethics. In the discussion of these two approaches we found that, even though the literature on both approaches seems to be rather polarised, both approaches cannot be exclusive of each other in their methodologies. Principles, and a principlist approach need individual virtuous agents in order for the principles to become meaning. Moral reasoning and deliberation is needed to give principles life. On the other hand, virtue ethicists need to acknowledge that they too act according to various sets of moral and ethical rules. Such rules need interpretation in order to find meaningful use in the life of the moral agent or groups of agents or community of agents.

We found in the discussion of these two approaches in the third part, that it is therefore not necessarily conducive to the cause of contemporary biomedical ethics if both methodological approaches become even more polarised in their argumentation. Rather, as this chapter concludes, there needs to be agreement on differences of both school of thoughts, but nonetheless also an understanding that principlists need virtue ethicists and vice versa; only in such mutual understanding can be meaningful contributions to contemporary biomedical ethics. A brief introduction to non-religious approaches to ethics was centred around post-modern approaches to ethics as well as feminist ethics. However, for the reasons of word limitations, such introduction had to be kept a minimum.

With this introduction to theological voices and philosophical reasoning in biomedical ethics, we are now ready to approach the body of this research among Anabaptist/Mennonite physicians. In their approach to virtue ethics – that seeks to embody Anabaptist theology and ethics in the daily practicing of medicine – we will find that the physicians stand in exactly the tension between (Christian) principles and moral agency.

CHAPTER II

INTRODUCTION OF EMPIRICAL RESEARCH AND RESEARCH METHODOLOGY

Introduction to the Chapter

In Chapter I of this dissertation we have been introduced to the involvement of theological and philosophical voices in biomedical ethics. We have been introduced to four contemporary scholars who contribute to the field of biomedical ethics from within their particular religious environment. We have then be introduced to two approaches of reasoning biomedical ethics, the principlist and the virtue ethics approach. These two methodologies seem to have a long history in biomedical ethics discourse, and seem to be at home in theological as well as non-religious approaches of ethical reasoning. The overall aim of this dissertation is to provide access to one such non-mainline theological approach in its application to biomedical ethics, namely Anabaptist/Mennonite theology. The specific aim of Chapter II is to utilise the result of the empirical research among Anabaptist/Mennonite physicians to show that non-mainline theological voices have their own unique contributions to make in the contemporary discussion in biomedical ethics.

In this chapter we will be introduced to the empirical research among Mennonite physicians. Firstly, we will learn about the methodology that is the basis of this research. Since the focus group of the empirical research is connected to a particular theological interpretation and social embodiment, the Radical Reformation approach, it did not seem useful to employ just only one methodology for this research. The combination of biographical-narrative analysis on the basis of grounded theory will provide the theoretical background for the introduction of data collection. Secondly, emerging ideas from the interviews will then be used to describe the particular ideas with which the physicians practise their skill. Reading interview excerpts about the biographical and theological/spiritual development of the interviewed physicians will provide the setting for emerging themes that are important to the physicians. This chapter will only describe the research from the initial contacts to the pilot study and to the main research interviews. We will be introduced to the actual taping of the interviews, the transcription and the coding, and

at the end of this chapter we will find the statements of the themes that have emerged from this research process.

It is important to note that this dissertation will focus on theological and ethics themes that have not yet been the major focus in biomedical ethics. We will be introduced to a variety of themes and issues in this chapter, not all of which could be dealt with in depth, due to lack of space and the word limitation. Additionally, not all the themes that have emerged from the interviews are equally applicable to biomedical ethics, therefore some themes will only be mentioned in this chapter and not have any major weight in the final analysis.

II. MODEL OF RESEARCH: QUALITATIVE BIOGRAPHICAL

A) Justification for Choice of Research Model

Biographical research in this dissertation refers to the process of gathering information through the individual life story of the interviewees, transcribes the collected information, and lets themes emerge from that collected information. From the emerging themes, the researcher will then try to make sense of the frame of reference that governs a person's conduct. We will be particularly interested in the connections between the physician's faith and how that faith conviction manifests itself in their everyday work in medicine. For the concept of this dissertation it is impossible to gather such information without hearing stories of growing up and of significant events and people in this growing up process. The social scientist Daniel Bertraux describes such a listening process as "our task as intellectuals to put together those bits of knowledge... and to draw a picture of the whole and of its movements".¹²⁶ For Bertraux, life history is the intricate way of finding out processes, and making connections with the things that shape the formation of a person's opinions, attitudes, and virtues. He goes on to state that the most useful way of understanding each other in our overly scientific world is narration.

"Collecting life stories gives us a sense of narration. It is a sense we have forgotten (but which is still very vivid in oral cultures) and which we have to *learn* again. Besides, everybody can read life stories and appropriate for him/herself the bit of knowledge that each one contains."¹²⁷

¹²⁶ Bertaux, Daniel. "From the Life-History Approach to the Transformation of the Sociological Practice," in *Biography and Society*, by Daniel Bertraux (ed) (Beverly Hills: Sage, 1981). 40.

¹²⁷ Bertraux, "From the Life-History Approach to the Transformation of the Sociological Practice." 44.

Similarly, in *Qualitative Data Analysis*, Ian Dey emphasizes that biographical research has to “describe the world as it is perceived by different observers...qualitative analysis is usually concerned with how actors define situations, and explain the motive which governs the action.”¹²⁸ Franco Ferrarotti also states that even though “the biographical method addresses itself to the individual”, this very method is used to locate the individual in the context of the social environment and all its shaping forces.¹²⁹ Similarly, Miller and Glasser call qualitative research a “possibility of exploring the point of view of our research subjects, while granting these points of view the culturally honoured status and reality”.¹³⁰ The collection of life story for biographical research is a well established approach in qualitative research methods. Contrary to quantitative research where the researcher is interested in finding common denominators in the highest number of participants, the qualitative researcher is interested in details of people’s lives, in common processes, in patterns of sameness in all interviewees, in forces that shape the individual, in short, in the entire life story. Summaries and emerging themes of such details become the measure for the qualitative researcher in order to establish common patterns and processes. Absence of similar details and patterns can provide the researcher with an entirely different outcome of the project than that anticipated or expected. Of the greatest importance in this process of biographical information gathering is listening, listening with a goal in mind but not with preconceived ideas.

The Anabaptist interest in connecting one’s life story research with other narratives provides substantial reasons and security for pursuing this empirical study with the proposed methodology. Mennonite sociologists Driedger and Kraybill reiterate similar notions in their book *Mennonite Peacemaking*.¹³¹ Even though their focus is on the changes in Mennonite peace positions of the 1960-1970s, they echo Bertraux’s insistence on narration through life story. Driedger and Kraybill credit modernity and technological application to all areas of life with the loss and underestimation of relationships that are much needed to help us make sense of our

¹²⁸ Dey, Ian. *Qualitative data analysis* (London: Routledge, 1993). 34.

¹²⁹ Franco Ferrarotti, “On the Autonomy of the Biographical Method,” in *Biography and Society: The Life History Approach in the Social Sciences*, by Daniel Bertraux (ed) (Beverly Hills: Sage, 1981). 26. Ferrarotti grounds his autonomy of biographical research in Gustav Simmel’s *Soziologie*.

¹³⁰ Miller, Jody and Barry Glaser, “The ‘Inside’ and the ‘Outside’: Finding Realities in Interviews,” in *Qualitative Research: Theory, Method, and Practice*, by David Silverman (ed) (London: SAGE Publications, 1997), 99-111. 100.

¹³¹ Driedger, Leo and Donald B. Kraybill. *Mennonite Peacemaking: From Quietism to Activism*. (Scottsdale, PA/Kitchener, ON: Herald Press, 1994).

personal life stories.¹³² Donald Polkinghorne also understands the researcher's data as "traces of past events, [that] help to uncover the events leading up to the phenomenon under investigation".¹³³ When researching a current phenomenon-in the case of this dissertation the contribution of Anabaptist/Mennonite theology in its use by the Mennonite physicians-it is impossible to draw conclusions only from present circumstances, one has to listen to the story of the past that has shaped the present in order to understand the present circumstances. Because the story, one's own biography, and personal experiences are important features in Anabaptist theology, it seemed naturally to adapt the biographical and narrative research methods for the use in this dissertation. The question to be answered was then which interpretive method was most suitable for analysis of the life stories of the Mennonite medical doctors in order to arrive at the desired results?

Another important reason why this research is based on a qualitative rather than a quantitative research method is the size of the sample. The Mennonite Medical Association is the professional body for Physicians who are members, or associate members of Anabaptist churches in North America. On one hand, the Mennonite Church USA, as well as other Anabaptist denominations are a comparatively small group. This means consequently that one would not expect too many physicians in such a small denomination. On the other hand, early Anabaptist/ Mennonites have put much emphasis on helping each other in form of mutual and mutual caring, as Graydon Snyder has observed.¹³⁴ This fact, combined with the Anabaptist propensity of living in rural rather than urban areas, has in the past led to an over- emphasis for teachers, nurses, and pastors. As we will see later in this chapter, the need for Physicians was not as pressing, and when one was educated as physician, he/she was usually trained to serve as medical missionary.¹³⁵ For the above - mentioned reasons, MMA is not a large professional group, and seemed to offer better in-depth information for qualitative research.

The choice of qualitative research method is not immune to criticisms, such as small sample size and non-generaliseable findings. As we will see shortly, for

¹³² Driedger and Kraybill, *Mennonite Peacemaking*, Chapter 2: "Modern Challenges and Transformation." 39-59.

¹³³ Polkinghorne, Donald. E., *Narrative Knowing and the Human Sciences*, by Lenore Langsdorf, (ed.) *SUNY Series in Philosophy of the Social Sciences* (Albany: State University of New York Press, 1988).174.

¹³⁴ Snyder, Graydon. *Health and Medicine in the Anabaptist Tradition: Care in Community*. (Valley Forge, PA: Trinity Press International, 1995). 75-89.

¹³⁵ Cf. Interview #1, #10.

biographical narrative analysis, a small sample size is much preferred over too many samples, because the research is focussed on internal processes of the interviewee rather than on comparative findings. As we will also see in Chapter IV below, common internal processes of the formation of character and identity has been found in all of the interviewees.

The criticism of non-generaliseable findings will be answered in the concluding chapter of this dissertation. There we will see that this original research into Anabaptist theology and ethics contributes the three main themes of servanthood, peace and non-violent justice, and community to the larger field of biomedical ethics. However, before these contributions can be brought to the wider field of bioethics scholarship, those theological and ethics themes need to be dealt with coherently by the members of MMA and the larger Mennonite Church in North America. As we will see in the following part of this chapter, narrative analysis plays a vital part in the process of analysing the findings and returning them to the original source of the research. Only when the original research subjects have received and processed the findings of the research can they then take the results and use it for further research. In the concluding chapter, we will therefore see that this original research with Mennonite physicians serves a double purpose: on one hand, it will challenge the physicians to be more conscientiously Anabaptist Christians in their medical work. On the other hand, it will also challenge the physicians of MMA to be more outspoken in the field of biomedical ethics from the conviction as an Anabaptist physician.

B) Narrative Analysis

For the purpose of this dissertation, narrative analysis appeared to be an almost organic choice in connection with biographical research. One reason has been mentioned already, which is the approach in the Mennonite tradition of living in close-knit, oral communities. In this tradition, one cannot tell his/her own story without telling the story of the family of origin or the family of faith. As we will see in Chapter IV on the Anabaptist Theology, such oral community culture has significant roots in the interpretation of early Anabaptist theology. Another reason to choose narrative analysis is the relative familiarity of the Mennonite physicians with this form of analysis, which is based on their life long exposure to stories in their

respective communities. In Anabaptist history, story telling is an accepted literary tool to convey and give meaning to the community and the individual.¹³⁶

Reaching back into Anabaptist history, we find identifications of the early groups of Anabaptists with the Exodus story and the gospel narrative. Early exposure to stories at home and in the church community helps to sharpen the ear of the listener and evokes personal and corporate analysis of the narratives. The most important reason to choose narrative analysis, however, is that analysis is not something that happens only in the privacy of the individual's mind or life, the interpretation is also shared with, and validated by, the community. The literary term of the 'hermeneutical circle' has been adopted early in Anabaptist interpretation and is still used, predominantly in biblical and historical studies in Anabaptist and Mennonite scholarship.¹³⁷ The Anabaptist interpretation of the hermeneutical circle happens in three steps: first there is the telling of ones story in the community; secondly, that story is interpreted in the community in light of scripture and other mediatory science, and thirdly, the individual, (or in some cases the entire community) will then encounter a transformation of reality.¹³⁸ In his chapter "The Hermeneutics of Peoplehood," John Howard Yoder points to several agents that shape this kind of conversation. To complete the hermeneutical circle he understands the community to need agents of direction, agents of memory, agents of linguistic self-consciousness, and agents of order and due process.¹³⁹ Even though the participation of every person is strongly encouraged in the community, particular processes are still important for the interpretation of the stories.

According to Catherine Riesman Kohler, accurate narrative analysis proceeds in similar steps. She seems to indicate that good narrative analysis is to be judged according to the following four steps: persuasiveness and plausibility, correspondence, coherence, and finally, its pragmatic use.¹⁴⁰ In the language of social

¹³⁶ Cf. Paul Thiessen, "Postmodern Practice and Parody: Dallas Wiebe's *Our Asian Journey*, in: *Anabaptists and Postmodernity*, by Susan Biesecker-Mast and Gerald Biesecker-Mast, (eds.) (Telford, PA: Pandora Press, USA. 2000). 106-119.

¹³⁷ Cf. Chapter 1 in Lydia Harder Neufeld's *Obedience, Suspicion and the Gospel of Mark: A Mennonite Exploration of Biblical Authority*. (Studies in Women and Religion, Vol. 5. Waterloo, ON, Wilfried Laurier University Press, 1998.) 1-20.

¹³⁸ This process of the hermeneutical circle is not unlike than the hermeneutical circle of Liberation Theology. Cf. Clodovis Boff, "Epistemology and Method of the Theology of Liberation" in *Mysterium Liberationis: Fundamental Concepts of Liberation Theology* by Ignacio Ellacuria, S. J. and Jon Sobrino, S. J. (Maryknoll, NY: Orbis Books 1993). 57-85.

¹³⁹ Yoder, John Howard. *The Priestly Kingdom: Social Ethics as Gospel*. (Notre Dame, IN: University of Notre Dame Press, 1984). 15-45.

¹⁴⁰ Riesman Kohler, Catherine, *Narrative Analysis*, vol. 30, *Qualitative Research Methods* (Newbury Park: SAGE Publications, 1993). 64-68.

science, Riesman Kohler re-states what Lydia Harder Neufeld and John Howard Yoder have said in theological terms, namely that

it is desirable to take work back to the individuals and groups that participated in the study... it is important that we find out what participants think of our work and their responses can often be a source of theoretical insights. Returning our interpretations to their home communities is also politically important.¹⁴¹

In reference to this research it will be of great importance to bring the finding of this dissertation back into the community of Mennonite Medical Practitioners for further consideration. Or, as Riesman Kohler stated, "validation in narrative studies cannot be reduced to a set of formal rules or standardised technical procedures...but needs to become basis for other's work".¹⁴²

Similarities between the Mennonite practice of the hermeneutical circle, and the sociological practice of narrative analysis was the most obvious reason to employ biographical research with narrative analysis as method for this research. The hermeneutical circle will be discussed at length in Chapter III, section I/B, and in Chapter IV, section I/A and C. The final reason to choose this method was an invitation by the Mennonite Medical Association to attend a meeting where the findings of this dissertation were discussed. That meeting was comparable to Riesman Kohler's fourth step of validation for this research project. The meeting took place in March 2001 at the Mennonite Health Assembly in Albuquerque, New Mexico.

II. PROCESS OF DATA COLLECTION: A PILOT STUDY

This section will describe the location of the research subjects for the pilot study, the collection of information via the internet, the demographic information of the pilot study, and a brief analysis of the pilot study interviews.

A) Location of Research: Mennonite Medical Association USA

All of the research subjects have participated voluntarily in this study, and all are part of the Mennonite Medical Association, a professional body of Mennonite physicians in North America. The first problem to solve was locating appropriate research subjects and making initial contacts with them. In order to solve this problem, the decision was made to conduct this research in an entirely self-selected mode. This was a risky decision because the result could have been anywhere

¹⁴¹ Riesman Kohler, *Narrative Analysis*. 66.

¹⁴² Riesman Kohler, *Narrative Analysis*. 68.

between no response at all or too many respondents for the project. The communication medium for the initial contacts were two denominational newspapers and the internet. In the spring of 1999 two advertisements were placed in an American and a Canadian denominational paper of the Mennonite Church, asking for volunteers for the research project. Two email addresses of the researcher were supplied for the anticipated responses.

1. Self Selection of the Participants

For the entire process of data gathering it seemed crucial to let the research subjects voluntarily select themselves as participants. To a very large extent there was no other option after the decision was made to use the internet as the medium for initial contact. Several positive reasons supported the use of the internet for the initial contact. One reason was the geographical distance between the researcher in Scotland and the research subjects in North America. The second reason to chose the internet was the time factor. The return of the demographics via email proved to be much more expedient than the return by regular mail could have been. The last reason for choosing the internet for the initial contact was flexibility. The researcher was not bound to one particular geographic place for the receipt of the email responses, but could receive and print the initial responses wherever she found access to the internet.

There are also of course some unintended results in light of choosing the internet. The first one is that not every Mennonite physician is connected to the internet, even in North America in the 21st century. Some were therefore not able to respond to the advertisements in due time. Choosing the internet for the initial correspondence certainly may have left some physicians unable to participate in the pilot study. A second negative effect could be that some of the responses might have been lost in cyberspace; the email address of the researcher might have been misread so that the responses never reached the researcher. This assumption is supported by the initial correspondence with one interested physician in Canada whose demographic questionnaire never reached the researcher. Another interested physician moved his residency to a remote location in Eastern Canada, which resulted in his inability to communicate further. Notwithstanding these difficulties, choosing the internet as communication medium for the initial contact with the physicians proved to be more positive than negative.

2. Data Collection

The members of this final research group of this study are medical doctors who have to be active members in their local Mennonite Church. The reason for including only physicians in this study is that literature seems to indicate that the doctor-patient relationship still appears to be among the most influential relationships in medical decision-making. For most patients, the word of the attending physician seems to carry a lot of weight in their decision-making.¹⁴³ In addition, the inclusion of nursing staff in the study would have broadened the data collection far beyond the parameters of this dissertation. Conducting a similar study with Mennonite nurses will remain the task for another project in the future.

Data collection began in the spring of 1999 with the placing of advertisements in two of the largest Mennonite periodicals, *The Mennonite*¹⁴⁴ and the *Canadian Mennonite*.¹⁴⁵ The adverts were asking for Mennonite physicians who would be willing to answer a short survey about an Anabaptist perspective in biomedical ethics. Two web-based internet addresses were supplied to which responses could be sent. A total of 12 interested medical doctors with Mennonite backgrounds responded as a result to these advertisements, indicating their willingness to participate in the study. These subjects were willing to answer a short demographic questionnaire and a few short questions on three case studies.¹⁴⁶ Of the twelve interested physicians, five returned the demographic questionnaire. The results of those questionnaires will be discussed next.

Of the 5 respondents, 3 were willing to be interviewed, one declined an interview for personal reasons, and one was unsure about an interview, mainly due to perceived lack of experience as MD. This respondent was in private practice for only three years and did not feel experienced enough to appropriately answer the questions about the case studies.

3. Returned Demographics

Of the five returned demographic questionnaires, four are male and one is female. Four physicians practice in the USA, two of them in the eastern United States and two on the West coast. One is practising in Western Canada. The average age of the respondents is 51.2 years, and they have been in practice an average of

¹⁴³ Cf. Pellegrino, Edmund D. "Philosophy of Medicine: Should it be Teleologically or Sociologically Constructed?" in *KIEJ*, Vol. 22:2 (2001) 169-180.

¹⁴⁴ <http://www.mph.org/themennonite/ad.htm>

¹⁴⁵ <http://canadianmennonite.org/>

¹⁴⁶ The demographic questions are found in appendix A, p. iv.

20.6 years. Their medical specialisations are family physician (3), one of which specialised later in obstetrics-gynaecology, and the other in psychiatry, one paediatrician, and one respondent is still in training to be an anaesthesiologist. Four out of five are active in their local Mennonite or Mennonite Brethren church, serving in areas such as music, children's programs, stewardship commission and choir, family life and life cycle commissions, teaching Sunday School and preaching occasionally. One is currently not active in a Mennonite church. Three respondents are from a Mennonite Church background and two are members of a Mennonite Brethren church.¹⁴⁷

B) Responses to the Case Studies¹⁴⁸

The volunteers were presented with three case studies, one study concerning questions at the beginning of life, one with questions at the end of life, and one with problems in a genetic counselling study. The beginning of life case study was about a young, divorced mother of three, who became pregnant again out of a rape situation. The question was how the Anabaptist/Mennonite physician would work with this case. Similarly, the case at the end of life of Mr. Brophy, which became a landmark case in the history of American biomedical ethics, was asking the volunteering physicians to comment on the case from their own Anabaptist/Mennonite perspective. The third case was that of a couple who came to an infertility specialist for help after their previous child had died of Fragile-X syndrome. As we will see shortly, this last case caused the strongest criticism among the volunteers.

The responses to the case studies reveal, first of all, a strong emphasis on compassion with the suffering of the patient. Compassion is defined by all of the respondents in the most literal sense, as 'com-passion, having passion with' those who suffer for whatever reasons. As the respondents indicated, compassion in medicine for them means going the extra mile. Or, as one doctor wrote in his response to Case #1.

She may very well want to keep the child despite any question of paternity or rape. One would especially then wish for emotional, psychological, and spiritual as well as physical help for both mother and child...Her history of past problems make for a high-risk situation. Church or community group support is highly recommended.¹⁴⁹

¹⁴⁷ Mennonite Brethren belong to the Anabaptist tradition but have split off from the main body of the Mennonite church in 1860 in Russia.

¹⁴⁸ For copies of the case studies see Appendix A, p. i-iii.

¹⁴⁹ Email response # 1, p. i, lines 9-14.

We can see in this response that the doctors see their work in a far-reaching, inclusive, and holistic sense which encompasses all aspects of life. As indicated above, networking and referring to other social support agencies is the daily bread of Mennonite physicians, but not only networking for the physical, social, and emotional well-being of the patient, but also assuring that the patient gets church or community support if he/she chose it.

Secondly, this example also indicates the often mentioned emphasis of tolerance with a patient in spite of disagreement about the decisions the patient might contemplate. All of the doctors who responded to the preliminary questionnaire and cases agreed that everything has to be done to keep the doctor-patient relationship intact. "No matter what she decides I would not reject her as a patient or person even if her choice conflicts with my own values."¹⁵⁰ Tolerance despite disagreements over treatment is an important issue for Mennonite medical doctors on several levels. One level is that their support of controversial decisions might put them in direct opposition to official Mennonite church statements. How are they supposed to behave in the church community after having participated in and/or supported a controversial decision? Moreover, do they see the church community as a safe place where they can discuss these pressing questions? On another level, tolerance is an important issue in the relation to other Christian medical doctors. It has emerged from the interviews that the *Christian Medical and Dental Association USA*¹⁵¹ (CMDA) is an organisation which is being treated with much concern by Mennonite medical doctors. The reasons are that the CMDA seems to lean towards a more legalistic approach than many of the respondents seem to be comfortable with. Tolerance is not an indiscriminate, liberal support of 'everything goes', rather it is understood as the discussion of options with the patient and support for the patient no matter what choice he or she makes. Interestingly enough, tolerance seems to have deep-seated theological roots for many of the doctors, but this theme will be discussed in the theology chapter, Chapter IV.

Thirdly, approaching decision-making in medical ethics from a peaceable and non-violent perspective seems to be another issue close to the heart of the Mennonite medical practitioner. Peace and non-violence appear as an implicit factor in all the responses, as well as the doctor's attitude to tolerance, and continuous support in the

¹⁵⁰ Email response # 2, p. i lines 23-24.

¹⁵¹ <http://www.cmda.org/>

absence of agreement with the patient seems to point to the physician's wish for inclusive and holistic health care.

"Though nutrition is a need common to all, providing it artificially is only a convenience of our modern technology. This technology is a real gift to those who have hope of recovery but a curse on those who would die and never recover. Life is a supreme value, but not *the* supreme value. Life must be treasured and protected but not preserved at all costs. There is a significant difference between actively taking life and allowing death in a situation such as Mr. Brophy's."¹⁵²

Other emerging issues are a strong emphasis on justice and just access to health care. These topics seem to be approached by the physicians from within their Mennonite theology. All of the respondents clearly defined a need for universal access to health care, the lack of which is a particularly poignant problem in the USA.¹⁵³ Justice in and access to health care is not only sought for those who may be able to pay a limited kind of health insurance but also for those citizens who cannot contribute anything to their health insurance. For the respondents to the email survey, justice in health care also seems to carry a strong tendency towards advocacy for the poor and just access to health care for every member of society. This last set of issues was again reflected on from a theological point of view; advocacy for the poor and justice lie at the heart of Anabaptist/Mennonite theology's interpretation of the teachings of Christ in the Sermon on the Mount.

Summary of Email Responses

In summary, the analysis of the email survey seemed to indicate a strong interconnection between faith and theological reflection and the medical practice of all the doctors that were preliminarily surveyed. Additionally, the following theological terms were used readily and emphatically: *stewardship over scarce resources* in relation to case # 3 on Genetic Counselling; *compassion for unbearable situations* as responded to in Case # 1, abortion; *injustice*, and *intolerance of accepting a patient's decision* as in the case of Mr. Brophy, Case #2. In comparisons with non Anabaptist or non-Christian colleagues, they described themselves as "less doctrinaire than them", "more tolerant", "more supportive in case of adverse decision of patient", "not pushing toward a quick fix but valuing the individual", "helping to find other options", i. e. adoption (case # 1). One final note: it is interesting that none of the three older, male, and very experienced doctors (age 55 with 23 years

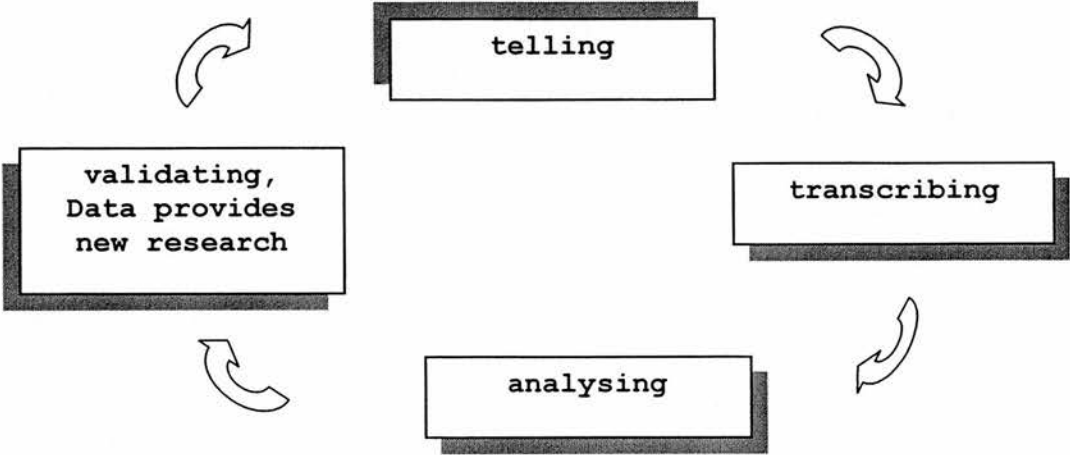
¹⁵² Email response # 2, p.1, lines 42-47.

¹⁵³ At the moment the richest nation in the world has over 50 million citizen who are not have any type of health care coverage.

experience; age 73 with 38 years experience, and age 68 with 38 years experience) ever mentioned any of the terms used in mainstream biomedical ethics such as autonomy, informed consent, beneficence, or any other terms. The two younger physicians, one male (age 33 with 3 years experience) and one female (age 30 in her first year of residency) readily introduced the principles of patient autonomy, informed choices, professional paternalism, beneficence, and nonmaleficence. At this point in the research it is unclear why this was the case but one would assume that it has to do with the education of a younger generation of physicians.

TABLE 1

Figure of Narrative Analysis



III. THE PILOT STUDY INTERVIEWS: DEVELOPING RESEARCH QUESTIONS

After the analysis of the email responses, it became increasingly clear that there seemed to be sufficient interest among Anabaptist/Mennonite physicians to participate in such the proposed research project. Two American physicians had indicated their willingness to be interviewed about their Anabaptist/Mennonite theology in relation to questions of biomedical ethics. But before the interviews could be conducted, adequate research questions needed to be formulated.

A) Semi-Structured Interview Questions

The design of the research questions for the pilot study challenged the researcher on two levels. First of all, the biographical nature of the dissertation needed to be considered in designing the interview questions; these questions needed to be formulated such that the narrative of the individual doctor's life could be uncovered. For that reason, questions had to be open-ended to give the interviewees enough freedom to explore the questions in any direction. On the other hand, the questions also needed to be somewhat structured in an attempt to solicit only the most relevant information from as many volunteers as possible. The second challenge was one that all researchers encounter, namely, to design interview questions which could trigger the creative thinking of the interviewees without simultaneously appearing to be too revelatory and leading. Another problem for the design of the pilot study interview questions was, that while the questions needed to be open-ended and structured, the questions also needed to give the interviewees enough liberty to explore issues from every conceivable angle. The researcher could not anticipate all areas into which the doctors could take the questions, but needed to leave the questions open-ended enough to ensure just those free explorations. It seemed that semi-structured interview questions were the best option for the kind of research subjects that had volunteered. Literature suggests that semi-structured interviews were the most appropriate choice for a qualitative research model, particularly when the subjects hold very strong convictions about issues.¹⁵⁴

In summary, the difficulties with the design of the research questions for the pilot study were an excellent learning experience for the design of the questions for the main interviews. The volunteers of the pilot study gave important impulses to

¹⁵⁴ VandeCreek, Larry (et. al). *Research in Pastoral Care and Counselling: Quantitative and Qualitative Approaches*. (Journal of Pastoral Care Publications, 1994). 101.

focus research questions for the main interviews, while at the same time pointing the researcher in directions not previously explored.

B) Pilot Study: Interviews and Results

The analysis of the email responses provided the opportunity to choose two volunteers for an in-depth interview. The respondents were contacted by email and a suitable time agreed on. The interviews were conducted in October 1999 while the researcher was invited to present a paper at Goshen College in Goshen, Indiana, and while attending the Second Annual Meeting of the American Society of Bioethics and Humanities in Philadelphia, Pennsylvania. By invitation of the volunteers, both interviews were conducted at the respondents' private residences; both interviews were conducted within two weeks. Each interview lasted approximately 1 ½ hours; both interviews were audio taped and brief interview notes were taken. The semi-structured interviews were based on open ended questions, giving the interviewees time and opportunity to take the questions in any direction they felt necessary. The volunteers were asked the same set of open ended questions.¹⁵⁵

Pilot Study Demographics

Both interview partners were male, the first one 74 years of age, with 38 years of experience as a medical doctor. He was a primary care physician who later specialised in Obstetrics and Gynaecology, mainly due to involvement in College Health Care. In 1983, he attended a Bioethics course at the Kennedy Centre for Bioethics at Georgetown University in Washington, D. C. It was then that his current interest in biomedical ethics was ignited, which led him to remain involved in issues of health care on a denominational level. He has never changed his area of medical specialisation. In addition to a 3 year voluntary medical assignment with Mennonite Central Committee, he is an active member in a Mennonite Church in the Midwest of the USA. He has been active there for 42 years, mainly in Family Life and Life Cycle Committees. In addition, he serves as a church delegate to his regional Mennonite conference, and still teaches occasionally at the nearby liberal arts college.

Respondent 2 is a 55 year old male, a practising physician with 23 years experience, who specialised in Psychiatry after 16 years in family practice; for the last 7 years he worked as a clinical psychiatrist. He lives and practices in the Eastern United States, where he also attends a local Mennonite church and is actively involved in teaching Sunday School and occasionally preaches. As a young

¹⁵⁵ The questions for the pilot study interviews can be found in Appendix A, p. v.

physician, he decided to choose alternative service to military service and chose to work as a physician in Central America instead. In addition, as a voluntary service assignment, he and his family lived and worked for seven years in an inner city clinic in one of the poorest southern states of the USA.

C) Response and Analysis of the Pilot Study Interviews

1. Peace, Non-Violence, and Advocacy

The most striking aspect of both pilot study interviews was the physicians' profound reflections in light of scripture and strong identification with Anabaptist/Mennonite theology. Their identification as physicians seemed sometimes identical with their identification as Mennonites. In fact, respondent #1 said :

One important thing for me is, I always wanted my medical practice and my physician's attitude to be closely aligned with my faith experience.... I'm a Christian physician, but every step of the way I'm Anabaptist, that's always there, if push comes to shove, being Mennonite is who I am. And my patients know that, there's no two ways about it.¹⁵⁶

It seems as if both respondents' identity as physician and as Anabaptist Christian was focussed on congruency between medical conduct and religious belief. They did not answer the questions once from the perspective of a physician, and later as Anabaptist/Mennonite Christian. Their identity seemed to genuinely reflect that of a Mennonite physician. No doubt both were committed to their professional ethics; however, in all of their reflections, one is left with the impression that their faith prompted them to an extraordinary measure of compassion in their work. Doubtful as it is, it cannot yet be established whether they were taught this compassion in medical training. It is more likely that their strong emphasis on service and helping people developed early in their lives and was substantiated through religious teaching and personal practice. "Underlying it all was a service motive, I wanted to do something to help people."¹⁵⁷

At that time [during his high school years] as a Mennonite Christian... you usually went into a service profession, either teacher or medicine... I was familiar with people who had done some sort of service in the health professions, like I eventually did go and do my I-W service in Puerto Rico after I did my residency. So I guess wanting to do some service for the church to people in general and not doing that service through military. It was a natural outgrowth of that [peace witness and service mentality], the belief of

¹⁵⁶ Pilot study interview # 1, p. ii, lines 52-58.

¹⁵⁷ Pilot study interview # 1, p. i, line 3.

caring for the body of Christ and in that extent for everyone, I think, influenced me also wanting to be part of [a] healing [profession].¹⁵⁸

The specific theological responses to the interview questions included peace and justice issues and their relation with, and application to, health care in America. Justice issues were approached first from a practical point of view, considering the lack of justice in the American health care system. Both respondents put the strongest emphasis on the lack of access to health care, especially for uninsured or minimally insured persons, the so-called 'working poor' in the USA. Both interviewees relied on their extensive experience of working in situations where they have seen the health care system fail people for lack of insurance. In reflecting on these experiences, and their feelings of incompetence in delivering adequate care, both seemed to be drawn back to the biblical mandate to advocate for the poor and marginalised (Ex. 22:20-26; Lev. 25; Math. 5-6; 25:31-40).

When I was in Mississippi...if I had a cardiologist who would treat my patients mean I would not again refer them [to this cardiologist]. We developed a list of consultants who would care for our black poor folks just as well as for anybody else...I guess that's the advocacy part of it. Maybe that's also part of our heritage; some people say your faith belongs into the church, it shouldn't be out in the political sphere. Well, as Anabaptists we tend to say 'no, we speak to government, we do speak for justice for all', and that's another role [of faith] and probably in health care we need to do the same thing.¹⁵⁹

Reflecting on the Anabaptist/ Mennonite church's history of peace, justice, and advocacy, this respondent seemed to try to apply the same convictions to health care. It was particularly striking in both interviews that advocacy did not stop with cases where doctor and patient were in agreement. On the contrary, advocacy extended to cases where the physician seemed to disagree with the patient's choice of treatment. Nonetheless, both physicians put strong emphasis on understanding the bigger picture in which their patients found themselves: socio-economic and psycho-spiritual circumstances of the patient were just as important for the respondents as was their competence in accurate clinical diagnosis of the patient's disease. Accepting patient's choices of treatment and offering continuing support on the road to wholeness was most important to both interviewees.

¹⁵⁸ Pilot study interview # 2, p. I, line 4, 19-26.

¹⁵⁹ Pilot study interview # 2, p. ix, lines 349, 353-363.

2. Tolerance and Community

A strong emphasis on continuous relationship with the patient brings us to another, equally important finding in this pilot study: tolerance and community involvement. Both of these terms have long and deep roots in Anabaptist history,¹⁶⁰ but it is surprising to find tolerance and community applied to questions of Anabaptist medical ethics as well.

Tolerance, first of all, was referred to by both volunteers at two very distinct levels of the doctor -patient relationship: as mentioned above, tolerating the patient's choices while extending the invitation to continue the patient's journey to wholeness. This process was found especially in respondent 2 who is practising psychiatry in geriatric long-term care. It seems that in this particular setting issues related to patient care do not have to be decided under the same time pressure as in Emergency Medicine or Surgery, even though in the context of college health care and in his position as gynaecologist, respondent #1 also emphasised tolerance with the patient's choice, and the possibility to continuing support. In both interviews, tolerance was more than the absence of coercion through paternalistic physician-patient relationships. In combination with compassion and the aforementioned service component, tolerance became more than a liberal concept of aloof individual expression of patient choice. In the expression of both interviewees, tolerance seems to be something of a 'stand-by support' or coaching, in which the physician has more of a background role, should the patient come and seek help again.

On another, more passive level, both physicians advocated tolerance in the physician-patient relationship while reflecting on experiences with another professional body, the Christian Medical and Dental Society of America (CMDs). Both respondents felt uncomfortable about public expressions of their personal views on tolerance in this conservative medical association for evangelical physicians. In fact, respondent #1 got very annoyed with what he called "a narrow, truncated view of bioethics, lets talk about the whole field".¹⁶¹ "In fact", said respondent #2, "I was a member of CMDs, and I often felt [that] many of their ethical positions were a bit more legalistic than I was comfortable with".¹⁶² For both respondents, the relationship with the patient in the process towards wholeness was valued more

¹⁶⁰ Cf. Chapter III on Anabaptist theology for details.

¹⁶¹ Pilot study interview # 1, p. ii, line 78.

¹⁶² Pilot study interview # 2, p. vi, lines 224-226.

highly than the rigid application of dogmatism in decisions, as they perceive it to be practised in the CMDS.

Both respondents' last and most striking emphasis was on community: the emphasis on the responsibility of the community in an individual's healing and decision-making process on one hand; but also on the community's involvement in advocacy and support of people with minimal or no health insurance. Advocacy was reflected on in light of the historical peace and advocacy witness of Anabaptist/Mennonite theology. Both respondents referred to the history of the Mennonite Mental Health movement. This work began as a result of young Mennonites opting for Civilian Public Service rather than military service during WW I. During WW II, many conscientious objectors worked in State Mental Hospitals, an experience which led many of these Mennonite believers to actively pursue change in this area of American health care.

So, we cannot only advocate to government but also advocate to other faiths, because some people look at our faith as a model in the area of service. And I think in health care, we don't have many general hospitals anymore, and the psychiatric hospitals are getting fewer, but our history of caring for those people came out of our resistance of going to war. The government assigned us to these mental hospitals for two years, but our CPS (Civilian Public Service) people saw what was wrong there and we have the Mennonite Mental Health story. Those who came out of there saw what was wrong and they either started to change some of those institutions or started some of our own.¹⁶³

Community was identified by both interviewees as the individual's primary faith community, a community which is not involved enough in an individual's processing about medical ethics, as both volunteers said. They identified at least three levels on which they want to see the community fill a supportive role: first, in the support of the patient and the discussions leading up to a medical ethical decision; second, the community is not involved enough throughout the various phases of care of the individual patient's illness; and thirdly, both criticised a lack of support in the 'aftermath' of a procedure of medical ethical controversy. The respondents based their very strong criticism on the common misconception that the church is not responsible for people's physical problems, but is perceived to be only the care-taker of the individual's spiritual problems. This concept, they both

¹⁶³ Pilot study interview # 2, p. ix, lines 376-384.

criticised, is “lacking a holistic approach and understanding of what it means to be a Christian”.

Summary of Pilot Study

In summary, it is important to point out that the responses of both interviewees were first and foremost based on the application of scriptures in their practice as physicians. Peace, advocacy for greater justice, and increased community involvement seem to stand out as the pillars on which they base their convictions and motivation to serve as medical doctors. Service can be identified as the main motivator of their medical involvement; service to both the Mennonite community and the world at large. Reflections about their work and about the need for an Anabaptist approach to medical ethics were primarily based on applying the example of Jesus Christ as found in the New Testament to their own lives. “Following Christ in daily life” seems to surface as the basic motive for their involvement in the healing professions. It can be concluded with some certainty that the Mennonite physician received his/her motivation to, and call into, service in a health profession early in his or her life. Various factors seemed to contribute to the choice of profession, “good grades in high school, the ability to do science, an underlying service motive, do something to help people, influence of a teacher, and a strong affirmation by my father who was a high school principal”.¹⁶⁴ In addition to this parental influences, a particular Mennonite ‘way of discipleship’ was also important for this physician.

I remember, one day I was in medical school, I got a phone call from the executive secretary of the Mennonite Board of Missions, he was passing through. He was a much revered leader and he gave me a call and asked me: ‘How are you doing? You know, the church is interested in how you are doing?’ That touched me. There was this leader who had an awful lot more to do than talk to this medical student. He took the time and talked to me.¹⁶⁵

Influence in the form of role models seems to be one of the hallmarks in the Mennonite understanding of discipleship; ‘keeping tabs’ on what young members of the church are doing in their education and careers is another important part of the understanding of discipleship. This kind of discipling is not just a means to an end for the Mennonite church to ensure her members are doing well. Discipleship in Mennonite understanding is based on Christ’s example of servant leadership. This interpretation of servant leadership is a way of life where one models his or her life after Christ’s example. In the process, one is not only personally transformed, but

¹⁶⁴ Pilot study interview #1, p. i, lines 2-3, 4, 8-9.

¹⁶⁵ Pilot study interview #1, p. ii, lines 47-52.

also impacts others and becomes a role model oneself. This is not the place to enter into the discussion on Mennonite discipleship; this topic will be taken up in the theological chapter of this dissertation, Chapter IV. However, we might be safe to assume from the pilot study, that discipleship has had a strong impact on both volunteers' choice of career and motivation to become a physician. The pilot study also suggests the importance of peace, community, and tolerance as vital issues in the construction of an Anabaptist/Mennonite medical ethics.

With these new insights into important themes for the development of an Anabaptist/Mennonite medical ethics, the next step in the research process was to find additional Mennonite medical practitioners who were willing to be interviewed. An invitation by the Mennonite Medical Association to attend their 2000 meeting in Canada provided the opportunity for completing this task. For a more comprehensive understanding of Anabaptist/Mennonite health care, we will now introduce the Mennonite Medical Association.

IV. MAIN RESEARCH INTERVIEWS

After the initial email contacts and the pilot study interviews were analysed, it was important to find a number of volunteers for the main research interviews. One of the pilot study volunteers initiated contact with the secretary of the Mennonite Medical Association, who in turn extended an invitation to the researcher to attend the annual meeting in Waterloo, Ontario, Canada in June 2000. All ten interviews for the main research interviews were taped at this meeting. Before we can enter the demographic data and the analysis of the interviews, we need to be introduced to the Mennonite Medical Association. This introduction will enhance our understanding of the physicians.

A) Mennonite Medical Association:¹⁶⁶ A brief historical Introduction

In May 1944, the Mennonite Medical Association (MMA) was founded in Pennsylvania with the goal of giving mutual support and encouragement to young medical students from a Mennonite or Brethren in Christ background.¹⁶⁷ In nearly 70 years of its existence, the association has grown from 10 to 595 members; 24 of those physicians are international members, and 18 are Canadian members. Even though MMA is the professional association for Mennonite medical doctors, the

¹⁶⁶ <http://www.mennmed.org/>

¹⁶⁷ Schlabach, Walter, E. and Willard Krabill. *Mennonite Medical Association: Faith and Fellowship, A History of the Mennonite Medical Association*. 3.

annual meetings are held in conjunction with the Mennonite Nurses Association and the Mennonite Chaplains Association. MMA is organised in regional chapters which meet semi-regularly during the year; these chapters were established to give support and encouragement to practising physicians and to discuss new advancements in medicine on a smaller and more intimate scale than the larger annual meetings. During the decades from the 1960s to the present, the most burning topic on the list of discussions seems to be changes in health care policy in the USA.¹⁶⁸ Early in the 1960s, Mennonite physicians felt strongly challenged in their 'peace church' theology as well as in their professional integrity. A questionnaire among the members of MMA in the early 1960s revealed that most of them are "involved in community and civic organisations, interested in community, church and nation".¹⁶⁹ The social identification of Mennonite doctors seems to be first with their faith community, then the larger community, and then with the nation.

Since 1980, MMA had supported the medical component of the China Educational Exchange Program which brings Chinese physicians to North America, and gives North American Physicians a chance to practise their skills at the Sichuan Province Medical University in Chongqing.¹⁷⁰

Another service and learning opportunity of MMA is the Student Elective Term (SET). 8-20 medical students participate annually in an exchange program with hospitals in Tanzania, Nepal, Zambia and India. This 8-10 week overseas experience for the student is 75% sponsored by MMA. The SET term seems to be a welcome challenge for young Mennonite medical students, as it provides opportunity for first hand experience of medicine in developing countries. The richness of their individual experiences can be followed in the SET-Corner in each edition of the Mennonite Health Journal.

In 1994 Mennonite Medical Association received the status of a tax-deductible organisation 501 (c) (3) with the Internal Revenue Service of the USA. This change in status has enormously boosted the slightly decreasing membership in the 1980s. Besides receiving tax deductions on annual dues, MMA members' further financial contributions to the association are tax deductible as well.

Regular activities of MMA are the annual convention and the publication of the *Mennonite Medical Journal*. Themes of the conventions have revolved more and

¹⁶⁸ Schlabach and Krabill, *Mennonite Medical Association*. 11, 24-26.

¹⁶⁹ Schlabach and Krabill, *Mennonite Medical Association*. 11.

¹⁷⁰ Waltner, Erland, "Health Education", ME, Vol. 5, 365-366.

more around health care ethics and its multi-layered problems for health care in North America. Since MMA is under the umbrella of the Mennonite Health Services (MHS) - an organisation which sponsors and governs all health care work connected to the Mennonite constituency in the USA - MMA and MHS have organised several meetings to discuss changes in the health care environment in the USA. These meetings were called 'Dialogue 92 and 93.' The meetings brought together "pastors and church officials, along with legal and health care professionals to discuss the church's role/mission in health and healing".¹⁷¹ A resolution on the reform of health care was drafted and adopted at the General Assembly of the Mennonite Church in 1993. The resolution included statements of missed opportunity and the lack of acceptance of responsibility on behalf of the church communities and those with whom they work. It also states commitments to values such as community, stewardship, justice, wholeness, and sacredness of human life in health ministry. It encourages support for, and commitment to churches in their development of health ministries and mutual aid strategies.¹⁷² Overall, it seems that the resolution of 1993 has given MMA a much needed incentive to increase responsibility to and involvement with local churches.

Besides concerns over public health care, biomedical ethics seems to have become another significant issue with MMA. Much time and resources have been spent to educate and inform members about current developments in medical science and related questions of biomedical ethics. It was in relation to this last question that the researcher has come in contact with MMA.

B) Presentation at Mennonite Medical Association

As indicated above, through a contact of one of the pilot study interviewees the researcher was invited to present a workshop at the Annual Meeting of MMA in Waterloo, Ontario in Canada in June 2000. This invitation provided the ideal opportunity to ask for volunteers for the main interviews. It was now necessary to proceed to finalise several outstanding issues in the completion of the data collection. First, in light of the pilot study analysis, the interview questions needed to be finalised in order to yield maximum information. Next, conversation ensued with the executive secretary over the procedure of demographic data collection of all

¹⁷¹ Schlabach and Krabill, *Mennonite Medical Association*. 25.

¹⁷² Copies of the various resolutions on health care are with the researcher. The latest 'Statement on Abortion' of the Mennonite Church USA can be found in Appendix B, p. xx-xxii.

attendees at the Annual Meeting, and about the most efficient method of subject selection. In addition, the researcher was well aware of her status as participant-observer. This meant more involvement than just being a neutral outside observer, but it also meant being less than a full member of the association. Presenting the workshop provided an excellent opportunity to engage in active listening to what the physicians had to say to questions of religion and health care.

The last area of concern was to establish rapport between the researcher and the individual volunteering physicians of MMA, both of whom had been complete strangers until the time of interviews. For biographical research it is essential to establish good rapport between the researcher and the interviewee in order to maximise the outcome of the interview. Britten calls that balance the “sensitive process of interaction between researcher and interviewee”.¹⁷³

1. Collection of Empirical Data for Main Study

The researcher and the executive secretary of MMA agreed that the most efficient way to collect the demographic data would be to insert brief information about the research project and demographic questionnaire into the conference folders of all attendees. This information was sent to the participants two weeks before the meeting. Before arriving at the annual meeting, the physicians could read about the project and decide whether they wanted to participate in the demographic questionnaire.¹⁷⁴ 23 of a total 47 participants at the MMA annual meeting of 2000 returned the questionnaire, answering general questions about matters such as age, gender, years of physician experience, area of specialisation, years of overseas assignment, etc. The analysis of demographic data and of the interviews will follow in the next chapter. The first question on the questionnaire is that of limited consent; limited in the sense that it authorises the researcher to use the personal name of the volunteer. A few of the respondents have taken the liberty to decline that use, some have not recorded their name at all.

2. Self-selected Subject Group

The researcher was introduced to the entire group at the first plenary session on June 15, 2000 by the executive secretary of MMA. Dr. Hostettler also introduced the demographic questionnaire in the conference folders, asking people to fill them in

¹⁷³ Britten, Nicky. “Qualitative interviews in medical research,” in *Qualitative Research in Health Care*, by Mays Nicholas and Catherine Pope (eds.) (London: BMJ Publishing Group, 1996). 30. Cf. Paul Atkinson, “The Ethnography of a Medical Setting: Reading, Writing, and Rethoric,” *Qualitative Health Research*, no. 5 (1992a): 117-124.

¹⁷⁴ See Appendix A for a copy of the questionnaire and the introduction to the research project.

and drop them off in a designated box. In addition, he encouraged participation in the study by pointing to a sign-up sheet that had been posted in a common area. The agreed length for the interviews was between one and 1 ½ hours per interview, therefore the sign-up sheet had been designed accordingly. The researcher hoped for a minimum of 5 interviews but 10 interested subjects signed up within the first 12 hours of the initial announcement by Dr. Hostettler. All ten interviews were taped between Friday, June 16, 2000 and Sunday, June 18, 2000.

3. Data Collection

Each interview was audio taped. The researcher took brief biographical notes in the beginning but then concentrated completely on listening to the answers of the interviewees. Each interview lasted between 1 hour and 1 ½ hours. Five open-ended questions were asked in the semi-structured interviews. The five questions had sub questions in case some of the interviewees were not clear about, or comfortable enough, with answering the questions as they were asked. However, only in two or three cases was the researcher pressed to rely on sub questions, in all other interviews answering the questions was not the problem. On the contrary, the problem was to bring the interviews to a close and come to an end, because of the amount of information the individual physicians wanted to volunteer. For a list of the semi-structured interview questions see Appendix A. Five of the interviews were conducted on Friday afternoon and evening, three on Saturday afternoon and evening and two on Sunday morning. Approximately three weeks after the conference, the taped interviews had been transcribed by the researcher.

C) Demographic Data for Main Study

The Mennonite Medical Association meets annually and alternates between sites on the East Coast of the USA, the Midwest or the West Coast. For the first time the 2000 convention was held in Canada, and attended by only 47 physicians. Such comparatively low attendance might be due to the fact that the convention was held in Canada for the first time, assumes executive secretary Joyce Hostettler.¹⁷⁵ The demographic analysis has already provided some remarkable findings. Since the

¹⁷⁵ Email of June 30, 2000. The 47 physicians were joined by 32 nurses and 50 various other attendants. A total of 129 adults and 32 children attended the MMA 2000 convention. This number is lower in comparison to the years when the convention is in Laurelville, PA. In 1999 saw an attendance of 169 members and in 1997 160 adults attended. The higher number of attendants at Laurelville might be due to a higher percentage of MMA members living and practising on the East Coast of the USA and Canada. This fact is supported by the geographical location of the present research, where the strongest geographical location is Eastern USA, followed by the Midwest (Ohio, Illinois, and Michigan). Only one interviewee was from the Canadian West Coast.

methodology for this dissertation is biographical-narrative analysis, it seemed unnecessary to use a computer based analytical tool for the demographic data.

1. Geographic Location

Of 47 attending physicians, 23 (48.93%) chose to return the demographic questionnaire. Of those 23 returned demographic questionnaires, 10 physicians (43.47%) volunteered to be interviewed. In regard to geographic location, 19 (82.60%) respondents are US citizens and 4 (17.39 %) are Canadian members. Overall, MMA has only 18 (3.15 %) Canadian members; this fact seems to indicate that the Canadian attendance was quite high at the 2000 meeting.

2. Years of Professional Experience

The 23 physicians included in the demographic questionnaire have a total of 604 years of medical experience, an average of 26.2 years of experience per physician. Six physicians (26.08 %) indicated a change of, and/or further training in their field of specialisation. All except one of these changes seems to have occurred either before or after a voluntary service assignment of the physicians. Reasons for change, or more specialised training, were indicated as change of interest or need for more physicians in a particular field; one respondent indicated family problems as a reason to change, and one physician indicated that the change in specialisation provided greater flexibility for voluntary service work.

3. Medical Specialisation

The choice of medical speciality among the respondents is another interesting observation. Twelve of the respondents (52.17 %) are primary care physicians in family practice. Two of those 12 have later changed over to psychiatry, and one has specialised in obstetrics-gynaecology later on in his professional life. Five of the physicians (21.73 %) have been trained in internal medicine, one of them went into disease control later, and another physician specialised in rheumatology. General surgery was indicated by 3 of the respondents (13.04 %), two of whom specialised in emergency medicine later. The remaining three physicians work in epidemiology/disease control, in diagnostic radiology, and as a paediatrician. For the sake of greater flexibility, the latter specialised in emergency medicine later in his career. Such a varied list of specialisations prompted several questions for the researcher: why have so many Mennonite physicians specialised in family medicine and internal medicine? What are the reasons why none of the respondents is in bio-scientific research, and why are only very few in public health and disease control?

Another interesting observation is that 2 physicians have significant medical experience with the Amish community. One respondent indicated the majority of his medical experience in this community (36 years), the other physician has 17 years' experience in a community with an approximately 40% Amish population. Again, the question begs asking, why these physicians would choose to practise family medicine in a rural setting in the Mid West of the USA rather than practise academic medicine or work in medical research? The answer to these questions should not be assumed here, but will be answered in the interview analysis below.

4. Demographics on Gender and Age

Of 23 returned questionnaires, 20 questionnaires (86.95%) were completed by men but only three (13.04%) were completed by women.

Another significant demographic finding is the age of the respondents. The average age of the physicians is 55.39 years. Fourteen of the 23 respondents (60.86%) are over the age of 50, seven respondents (30.43%) are between the ages of 40 and 49, and only two respondents (8.69%) are under 39 years. There seems to be a significant age gap between the under 39 year old physicians and the over 50 year old physicians. This age gap could be related to the life stage and career engagement of many of the physicians who are under the age of 40.

5. Voluntary Overseas Assignments

Another significant demographic finding is the amount of time spent on voluntary overseas assignments. Eighteen of the 23 respondents (78.26 %) spent a total of 101.6 years in voluntary medical service overseas or on Indian Reservations in the South West of the USA. Fourteen (77.77 %) of those 18 went as certified physicians into voluntary medical service, whereas 4 respondents volunteered between 1.6 and 6 months as students overseas. Four went as students and were sponsored by MMA's Student Elective Term, and one volunteer was sponsored by the General Conference of Overseas Mission. Sponsors of the various voluntary assignments were mostly Mennonite organisations, prominent among which are Mennonite Central Committee, closely followed by Mennonite Board of Missions and Eastern Mennonite Missions. One volunteer assignment was with the Brethren in Christ Mission.

6. Denominational and Conference Involvement

Twenty of the respondents (86.95%) indicated a membership in the Mennonite Church USA, two (8.69%) are members of the Mennonite Church in Canada, and one respondent is from the General Conference Mennonite Church. The

total years of membership in their respective churches is about 441.5 years for all 23 respondents. That makes an average membership of 20.7 years per respondent. The list of service in the local churches was indicated as follows: the favourite area of service is Sunday School, followed by music and worship leading, and serving as Elder. Other areas were health and family life commission, trustees, youth work, pastoral search commissions. The listing of service areas ends with involvement in church council, pastoral care commission, and peace commission. The questionnaire indicates that higher involvement in the local church excludes equally high conference participation. All of the respondents are involved in their local churches, but only ten (43.47%) of the total 23 are also active at a conference level. This conference involvement includes being a delegate to either their regional conference or to MCC, working on Mental Health Commissions, Peace and Service Commission, and Nominations Commission; one respondent indicated ongoing resource work with Eastern Mennonite Missions. Additional voluntary involvement was indicated as work with the Gideons International and ongoing work as medical director in a developing country.

Concluding Remarks to the Demographic Findings

The findings of the demographic analysis have uncovered interesting trends within MMA. These trends should not be taken lightly, but can provide grounds for closer examination and re-direct attention to appropriate black spots. However, since this dissertation is based on a qualitative research method, generalisations of these demographic findings of this research to the larger Mennonite church in North America should be avoided.

Voluntarism

First of all, the researcher found a remarkably high level of voluntarism. This discovery is not at all surprising, since the Anabaptist movement, and by extension the Mennonite Church, have been founded on the premise of the voluntarily gathered community of believers.¹⁷⁶ Voluntary service is understood as the practical application of one's gratitude for received grace. For the physician, volunteering time and resources means to invest him-or herself in a project that helps those in need. In the chapter on the theology of Mennonite ethics, Chapter IV, we will investigate the intricate pattern of the interrelationship between voluntarism, service, stewardship, and community. Here we can only state the obvious finding that 78.2% of the respondents have done voluntary service as physicians. What kind of social

¹⁷⁶ Cf. Chapter IV and V of this dissertation.

processes, besides teachings of the church, might prompt an individual to volunteer time and resources as a physician? If the indications of the demographics analysis provide any clues, we will find answers to these questions in the analysis of the interviews.

Gender

Secondly, the researcher was surprised by the comparatively strong gender imbalance within MMA. If this relatively small sample of physicians within the association gives us any lead, then there is a significant gap between male and female membership. A ratio of 86.9% male physicians to 13.4% female physicians prompts a lot of questions for the researcher. Are there women within the association who do not attend meetings regularly? If so, do these women not attend the meetings for lack of acceptance and/or encouragement to be there? Do they feel that their voices and opinions are not important, or are they attending other medical association meetings? In the larger Mennonite constituency, are women encouraged to attend medical school, or do official church statements neglect support for women's career choice in medicine? Would a greater gender balance also balance the professional and theological perspective within MMA if more women physicians attended the meetings and/or were more actively involved in the association? What could be done to facilitate and encourage more female participation within MMA? What kinds of action are already needed at the student level, to further the interest of female medical students in participating in MMA? It should be in the interest of the Mennonite Medical Association to increase the number of female participants and thereby strengthen the voice of MMA in the larger Mennonite constituency.

Age

The third, and obviously very worrying trend for the researcher, is the age finding of the analysis. 55.9 years as the average age is high indeed. There are certainly factors which will speak to this high age group. One factor might be the long preparation time to qualify in the profession, and consequently, another factor might be the intense time investment once the physician is established in his or her field. These factors might prevent attendance at meetings or membership in the association. Another reason for the age level in this sample could also be the location of the 2000 meeting which would have required long travelling hours, an investment impossible for many members. Whatever the reasons might be for the high average age, MMA might want to take this fact into serious consideration if they want to stay a viable and active medical association.

Conclusion to the Chapter

In this chapter we have been introduced to the empirical work on which this dissertation is based. We began with an overview over the methodology biographical research. This dissertation is based on qualitative model that is interested in common themes that emerge from the interviews. Therefore it seemed appropriate to use the Grounded Theory approach for the analysis of the narrative of the biographies of the Mennonite physicians. By comparing emerging themes, commonalities were established which will become the basis of the following chapters.

We have also been introduced to the entire process of finding the interview subjects. This process began with advertisements in Mennonite periodicals, continued with the first email contacts to the volunteers, and cumulated with the two interviews that make up the pilot study. After the pilot study had revealed a deep interest for the proposed research project, the main interviews were taped with volunteers at the 2000 convention of the Mennonite Medical Association. At that convention, the researcher was a participant observer and had the opportunity to meet with ten volunteers to tape the main interviews.

In the last part of this chapter we find an overview over the demographic data of all the attending physicians at the 2000 convention of MMA. Even though the demographic findings are very interesting, and can provide helpful insights into MMA, they are not the main focus of the empirical work. The important focus of this chapter is to establish common themes that can be found in the interviews. So far we have encountered themes of peace, non-violence, justice, tolerance, and community. The volunteers of the email responses as well as those two pilot study interviewees have stressed the need to include the particularly Anabaptist/Mennonite themes into considerations in biomedical ethics.

It will now be the task of the next chapter to verify, and maybe even enlarge, these themes in order to establish a broad basis for the contributions of Anabaptist theology and ethics towards contemporary biomedical ethics.

TABLE 2

Figure of Research Design



CHAPTER III

INTERVIEWS AND INTERVIEW ANALYSIS

Introduction to the Chapter

In the previous chapter, we followed the empirical research from the initial email contacts to the completion of the pilot study interviews. We have already seen in the email responses that the Mennonite physicians seem to put much emphasis on three themes: one is the theme of service, the second in the question of tolerance in the physician-patient relationship, and the third one is the rather complex relationship of the individual with his or her community. These themes have been solidified in the pilot study interviews which have been conducted with two volunteers from the pool of email respondents. The two physicians of the pilot study substantiated again the idea that Anabaptist/Mennonite physicians seem to be significantly influenced by their theological and ethics heritage; a heritage that they try to embody in their work as physicians.

After analysing email responses and taping the pilot study interviews, the researcher was then invited to be an observing participant in the annual meeting of the Mennonite Medical Association 2000. There she had the opportunity to interview ten volunteers from among the attending physicians. In this chapter, we will include the actual interviews in Part I. In Part II of this chapter we will analyse the interviews and try to see what kind of principles might emerge for an Anabaptist/Mennonite biomedical ethics. Because of the immense amount of interview material, it is impossible to copy the entire interviews. All the interviews can be found in their entirety in Appendix A of this dissertation. The interviews have been numbered from one to ten, and will be referred to as such in the footnotes. It is also important to be clear about the fact that these interviews have provided multiple layers of interconnected themes. Because we are interested in the contributions that Anabaptist/Medical Ethics can make to questions in contemporary biomedical ethics, we will focus mainly on theological themes that emergent from these interviews. In Chapter IV of the dissertation, we will trace the emerged themes in their theological development within Anabaptist/Mennonite theology and ethics. In Chapter V we will relate the thoughts of John Howard Yoder to the themes emerging from the interview analysis. Yoder has probably been the foremost Anabaptist theologian of the 20th century. For an application to issues and questions in biomedical ethics, we will use

Chapter VI, where we will engage in a discussion in current questions of ethics in biomedicine.

I. INTERVIEW EXCERPTS

A) Brief Demographics of Interview Volunteers

Ten (43.47%) of the 23 respondents volunteered to be interviewed for this analysis. Nine men and one woman met with the researcher to answer five questions within one and one-half hours time. Two of the volunteers were Canadian members, the other eight volunteers are located in the USA; five volunteers reside in the Mid-Western USA, two on the East coast, and one has retired to the West Coast. There was no respondent from any of the Southern States in the US.

The median age of the volunteers is 56 years with a total of 17 years and nine months of voluntary service experience overseas and on Indian Reservations. At a total of 192 years medical experience, the average number of years in practice is 27.4 years each. There are 4 general practitioners, one of whom went into psychiatry, two interviewees practised in internal medicine with one leaving for epidemiology, and one interviewee was a general surgeon who later specialised in emergency medicine. The average length of church membership is about 24.4 years, with activities such as Sunday School teaching, worship leading, music, services as elder, and peace committee work. Only three of the seven interviewees were active at a conference level, one with an ongoing involvement in overseas medical work.

1. The Interview Questions

Approximately two weeks after the interviews were taped, the researcher transcribed all ten interviews. Since this is a word-based, qualitative research project, it seemed important to invest considerable amounts of time reading and re-reading the interviews before coding and analysis was to be attempted. According to the Grounded Theory approach it is necessary to let the interviews speak for themselves and to “generate an inductive theory about [the] substantive area”.¹⁷⁷ Grounded theory seemed to provide maximum flexibility to work with the text of the interviews, because it allows great openness in letting themes emerge from the text.¹⁷⁸ A more in-depth discussion about various steps in the coding and analysing process are found at the beginning of Part II of this Chapter. There we will also discuss the

¹⁷⁷ Glaser, Barney, G. *Basics of Grounded Theory Analysis*. (Mill Valley, CA: Sociology Press, 1992). 16.

¹⁷⁸ Glaser, *Basics of Grounded Theory Analysis*, 25.

process of coding and classifying the enormous amount of interconnected ideas that the physicians brought up in the interviews.

A complete copy of the interview questions can be found on page IX of Appendix A. These questions are an expanded, and more detailed version of the questions that were used in the pilot study. The basic direction of the pilot study questions have been kept, but sub-questions have been added and formulated in a more nuanced way. This step seemed necessary after the pilot study, because both of the interviewees appeared to be somewhat overwhelmed when they were asked the questions. The more nuanced sub-questions provided the interviewees with the possibility of hearing the same question verbalised in a different way, which seemed to enhance understanding.

B) Theological Themes: Service, Compassion, Caring, Servant

The most prominent of all remarks in the interviews can be grouped under the heading of *servanthood*. In Mennonite understanding this is not an abstract term, but includes other, frequently mentioned motives like service, stewardship, caring and compassion.

Servanthood is a concept that draws mainly on the example of the life of Christ in the gospel narrative. It is doctrinally anchored, but does not seem heavily emphasised in the creeds of the Protestant churches.¹⁷⁹ However, as we will see in the later discussion on Anabaptist Theology in Chapter IV, servanthood is an attitude adopted as a result of one's conversion and practised and as expression of one's personal faith. Jesus' example of washing his disciples' feet is often taken as the Christian's call to serving instead of ruling (John 13:12-17). This servant attitude one can certainly find in many Christian churches, but it seem to have been one of the most significantly defining marks of Mennonites. One of the interviewees defined his understanding rather pointedly, saying,

... Even in the GP part [before he went into psychiatry] I think there would be some general influence of the church, which of course would not be unique to Anabaptist, that would be the serving part, but that certainly had been a strong area of Anabaptist/Mennonite professional development with teachers and nurses and eventually medicine became one too.¹⁸⁰

¹⁷⁹ Neither the Nicean Creed (382) nor the Creed of Calcedon (451) put much emphasis on Jesus' life as an important example for humanity to live by. In both creeds Jesus was crucified, died, buried, rose again, and ascended to heaven from where he will come again. See Tony Lane, *The Lion Book of Christian Thought*, (Oxford: Lyon Publishing, 1984). 28-30, 50-53. In the gospel narrative however, it seems that Jesus himself was very clear about the importance of following him in John 7:17 and John 17.

¹⁸⁰ Interview # 4, p. i, lines 42-46.

Service, as one expression of servanthood, was most frequently used by the physicians to describe primary reasons for their career choice. It seems that very early in their lives, all of them encountered another person who was instrumental in teaching such a service attitude. One physician puts his thoughts in the following context:

The strong emphasis on service that was a repetitive theme on our local Mennonite Church certainly supported my interest in the medical profession. Returning missionaries often visited our local church. Many missionary couples included at least one spouse that was a physician or nurse. The idea of service, of helping people with limited access to other resources, and doing so in exotic, distant places captured my imagination.¹⁸¹

One of the younger physicians helps to clarify reasons for the choice of career for past generations. He is in a position to do this, since he is the third generation of physicians in his family.

I think the service orientation of the church would be the primary thing...Almost uniformly, at least the people I met at that generation [the grandparents of the interviewee] who became physicians, they all were missionaries. That was sort of the justification for being able to get a higher education was to go the mission field and serve. So the service was the primary driving value in allowing the education that it took to become a physician. I think it's more my dad's generation where Mennonites actually become physicians and not necessarily missionaries. ...They were staying home serving the rural communities or the cities.¹⁸²

Whether one wanted to be a missionary and needed to be a physician to accomplish that task, or wanted to be a physician and needed to 'justify' it by working as a missionary, the service motive can be strongly felt in all of the interviews.

Stewardship is another issue that is foremost in the thoughts of most interviewed physicians. Stewardship is understood in a broader sense than solely economically; it is referred to as stewardship of time, of relationship, and of investment of ideas of justice and life style.

I am surprised I have as much in pinning down as I do, but the economics of faith, the ethics of how we live and serve in the world, how we consume resources...I haven't explored the issue in much depth, I guess I am troubled by the amount of wealth accumulated that we Mennonites have become comfortable with. How do you live authentically with that dynamic?¹⁸³

There [in the up-bringing] was an emphasis not on making money but on lifestyles that were in keeping with the theology, I guess you could say. And

¹⁸¹ Interview # 1, p. i, lines 20-25.

¹⁸² Interview # 10, p. i, lines 18, 43-50.

¹⁸³ Interview # 7, p. ii-iii, lines 77-79, 95-97.

so any of those caring, healing sort of things have been looked at positively. Even though I think my parents probably gave us lots of choices also... But I think in most churches, medicine and the caring professions and teaching, and some of the professions that were health [related] with people were accepted. So saying I want to get into business and become rich, if you made that kind of a statement would not have [you] getting any points or the same amount of support.¹⁸⁴

It seems that caring, service, compassion, and stewardship are inextricable links in the physician's practice and his or her Anabaptist theology. For the physicians, servanthood is not solely adhering to doctrine, it is much rather a choice of life style which they want to embody in everyday situations. One physician, who grew up in India and went back to India for another 15 years of medical missions after medical school, related the following pointed story about influences on his choice of career.

But I can still remember as a real little kid, you know, somewhere before the age of 7 or so, we were located in a rather isolated town, Corba, and Dad, you know, even though he wasn't a doctor, and he would be assigned things, my mother would help him with things like lancing boils you know, and stuff like that. This is probably pre-antibiotic era. And I could still remember, we kids went over there one time and somebody had been mauled by a leopard, I don't know whether the fellow made it or not. But I can still remember looking at the sheets on the bed when he came in, with a whole bunch of dried blood and stuff, and apparently the fellow had been very badly mauled and that left quite an impression. So, before coming to India my mother had a little bit of nurses training, essentially she was a teacher, and had a little bit of nurses training, and the missionaries at that time were courageous people, they did what they could for whatever the situation was. Then there was also a nurse up there by the name of Augusta Schmidt, who also later on I guess came to that particular station. So I guess these were the original sources of interest. So anyhow I resolved after reading that book [*Johnny's Crutch*] that I was going to go to Africa.

Well it became pretty obvious after I grew up a little further, there was no particular reason to go to Africa, there was plenty left around in India to do. So I supposed that was sort of the beginning of my career, whether, actually the folks (this is later on) they transferred down to Jangishpoor. And Jangishpoor had a hospital; fellow by the name of Dr. Dester, had come out there and established a hospital back in about 1927/28. So he heard that I wanted to be doctor, so he said fine: "we will check that out, you wanna work in the hospital during your vacations from highschool?" I said, "oh yeah". So I was a funky in the pharmacy, had to wash the bottles you know, and had to clean the place up, and I had to mix the ointments you know, and all that kind of stuff. But then, the advantage of that was that I also got to go in and watch Dr. Dester to do surgeries. So these were sort of the beginnings, but by that time you know, I had pretty well decided that I wanted to become a

¹⁸⁴ Interview # 2, p. i, lines 15-19, 20-24.

physician. And whether this had any distinctive connections to Anabaptism, I have not the slightest idea.¹⁸⁵

Helping and doing something worthwhile with one's life has been another important issue in the following excerpt:

For my choice, yes. I remember when I was deciding what to do with my life, when I was realising that I like science and health and so forth, I remember having just a real fear that the worst thing that could possibly happen in my life would be that I would live my life and get to the end and realise I haven't helped anybody. I just felt more fear and concern that I could live a life that didn't help other people than that I would live a life of poverty or a life of illness or whatever, nothing. No fears of being lonely or anything, nothing seemed more fearful to face at the end of life than that I had lived selfishly.¹⁸⁶

Another of the physicians told of the incident when he made a contract with God that led him to the choice of career of becoming a missionary doctor

I think service is a very big thing. I was just recalling, when I was 15, my Dad was really sick as a farmer, and I remember making a contract with God, if he would get better, to become a missionary doctor. I've been a doctor now for 29 years but only 8 of them have been overseas. But anyway, service is a really high priority.¹⁸⁷

In the course of reading through the interviews, it became readily apparent that it was impossible to divide various themes neatly. Most of the physicians seemed to relate their work as physicians with their faith and the teachings of the Bible very readily. Growing up Anabaptist/Mennonite inextricably linked the physicians with a variety of themes that were important in their developmental years. Besides themes like service, caring, helping, and stewardship, another important focus is around peace, justice and non-violence.

C) Theological Themes: Peace, Justice, Non-Violence, Access

Probably # 1 is that the teachings of Christ went far beyond anything we would normally consider as guiding principles. Taking the Sermon on the Mount seriously, that has a lot to do with how you approach things in general: political things, way of life, ethics, moral principles. And we are followers of Christ when we in all seriousness take very seriously his words. And not only that but you saw that those were lived out in reality in Christ's life.¹⁸⁸

Taking the gospel of Christ seriously, particularly the teachings of Jesus as collected in the Sermon on the Mount, is another emphasis of the physicians. Their personal interpretation of Jesus' teaching seems to be closely related to the

¹⁸⁵ Interview # 5, p. i-ii, lines 31-60.

¹⁸⁶ Interview # 3, p. i, lines 11-18.

¹⁸⁷ Interview # 8, p. i, lines 11-14.

¹⁸⁸ Interview # 5, p. iii, lines 98-103.

Mennonite understanding of peace and non-violent justice.¹⁸⁹ The Mennonite peace position and non-violence attitude is based on the teaching of Jesus to those who had become disciples (Mth.5-7). For a Mennonite it is therefore important to stress that those who are part of the new kingdom order live according to different standards, standards that Jesus has set with his life. Mennonite history is saturated with stories of men and women who would rather die than hurt another human being with violence.¹⁹⁰ However, not only are peace and non-violence important in Anabaptist/Mennonite theology, the ethical embodiment of such a theology, namely doing justice (Micah 6:8), is also very important to Anabaptist/Mennonite physicians.

Oh, I just look at Jesus' example, who are the kind of people he related to? He didn't advocate for the rich, but he sure advocated for those in need and the sick and the beggars and the people who didn't fit into their society and so on....And so if there is one thing that's important [it] is this whole thing about walking with people. And I think that's what Jesus did, yea, I think that's where it is.¹⁹¹

The question for the physicians is then how this interpretation of peace and justice can be applied in their work. Would their work be different from that of other physicians, Christian and non Christian alike? Does the Mennonite understanding of peace and non-violent justice provide a viable option in health care and questions of biomedical ethics?

The peace position, it certainly influences a lot of the ways you might approach issues at both ends of the life spectrum, abortion and dealing with pre-mature infants and so on, with death and dying. But I don't know that impacts as many of the ethical decisions that we face as things like justice, and being a servant...One of the real conflicts I think is most of the distributive justice [issues] are really being tackled at a federal government or state governmental level. And Mennonites historically had been uninterested in interacting with politicians on either of these levels.¹⁹²

I think there has to be allowance for the individual to have access...We are a kingdom of priests, every believer is morally responsible before God, we don't believe that the church is a bunch of Indians with a couple of chiefs. We believe we are all chiefs, we all have access to God, we all have the moral obligation to live out in our day to day life. There is no getting the

¹⁸⁹ Cf. Article 22 in *Confession of Faith in a Mennonite Perspective*. (Scottsdale, PA: Herald Press, 1995). 81-84. Comparing this confession with the older *Confession of Faith*, also called *Dordrecht Confession*, Article XIV "Defence by Force," gives great insight into the reasoning on peace and non-violence of earlier Anabaptists (LaGrange, IN: Pathway Publishers, 1994). Cf. Article VI in the *Schleitheim Confession* (trans. John Howard Yoder, Scottsdale, PA: Herald Press, 1977).

¹⁹⁰ Cf. van Braght, Thieleman, J. *The Martyr's Mirror*. (Scottsdale, PA: Herald Press, 1972).

¹⁹¹ Interview # 2, p. viii, lines 336-338, 343-345.

¹⁹² Interview # 10, p. v, lines 185-189, 193-196.

doctor off the hook were the ethics committee decided, in Mennonite ethics the doctor is still that patient's advocate.¹⁹³

Well, there are two things: respect for all people with the bias for life. Choice is a bad word because of all the pro-choice people, but respect for choice, I think I have to leave room for choice. [There is] something that says you respect their individual worth and the desire and their opportunity to find that [choice]... Maybe if I could [choose a] word it is compassion for the disenfranchised, I mean we need to really advocate for them and people choices. I guess in the health care system I want to advocate for those people who don't have an advocate. Maybe it would be more making sure that the rights of the underdog are also included.¹⁹⁴

These examples show how the Mennonite physician tries to conceptualise peace and non-violent justice into issues of just access to health care for everyone. This particular problem in the North American health care system seems the most pressing issue for all of them in their daily practices. Many of the physicians seem acutely aware of the discrepancy between their high earning careers and so many patients whom they serve who are unable to get adequate care.

D) Theological Themes: Community, Community Support for Patients and for Physicians

The last issue of theological-ethical importance for the Mennonite physicians seems to revolve around ideas of community. In this case, community is defined around three levels of community: first the church community, secondly, the larger Mennonite community, and lastly, the greater world community.

The importance of the community in the Anabaptist tradition has implications for the individual-population ethical conundrum. However, I'm still trying to resolve this issue for myself.¹⁹⁵

And then the non-resistance, non-violence aspect could have a lot of influence on some of these decisions. Like forcing people to live longer by doing some intervention, something like that. Decisions of competency, does community enter into that? Just when it comes to resources too, ideas about community say a lot about [our] use [of] resources instead of just individualism. And then servanthood, that would have a lot to do with the attitude with which we do things, how the structures should be. Those are a few things I can think off hand that are more unique to the Mennonite theology as opposed to the other theologies or Christian theology in general.¹⁹⁶

¹⁹³ Interview # 3, p. viii, lines, 321, 326--332.

¹⁹⁴ Interview # 2, p. vii-viii, lines 303-305, 309-310, 317-319, 324-326.

¹⁹⁵ Interview # 1, p. iii, lines 117-119.

¹⁹⁶ Interview # 4, p. vii, lines 277-285.

In this last excerpt we can see this physician cannot tackle just one issue when he tries to relate his theology and ethics to questions of everyday biomedical ethics. Both physicians point to the significance of community in Anabaptist/Mennonite theology and ethics, the issue of the community helping to make decisions, and the community's resources when aid is needed.

In Anabaptist/Mennonite theology, community help has always been a major emphasis. This physician who works close to an Amish community in southern Indiana assumes that it is really in the Amish community where mutual help and support is still very much practised.

I guess I'd like to believe there is some authenticity, people who work around the Amish often times get a lot jaded about the whole thing and reduce it to just financial terms or paternalistic, patriarchal kind of issues. I'm convinced that there are some Amish who truly see life value differently than the surrounding culture. And some of this goes back to my experience of Native Americans, who in some ways embodied AB values better than many AB. The fulfilment of one's purpose in life can be quite full at an early age. If you've raised a family, if you've lived a life of several decades, then life is not to be clung to at that point. And the Anabaptist thread of community, living as a member of a community where you don't take excessively, from the community but share, I know that is an issue for some of the Amish as well, for they consider health care to be a high cost resource to be expended very carefully because it is a community resource. They deliberately refuse health insurance. I'm not clear on that, my assumption, and I think I'm somewhat safe in this, is that they shun every program that is outside of the church. The concept of mutual aid is alive and well but it is within the community, it is not outside with the non-Amish. So, reliance on God and reliance of the help of each other is pretty much where health is thought.¹⁹⁷

The question of the relationship between the individual and the community is a double edged sword. On one hand, community would not exist if certain individuals had not decided to live together as a community. But on the other hand, the question of individual autonomy vs. communitarian involvement cannot be dismissed without exploring its inter-relational questions. We also see that the Mennonite physicians understand the interdependent relationships between servanthood, peace and justice, and community. These excerpts seem to suggest that the physicians are unable separate these three concepts in their understanding of what an authentic Mennonite physician is, or should be.

It shall be the burden of the application of the Anabaptist/Mennonite principles of Chapter VI to make connections between these theological-ethics

¹⁹⁷ Interview # 7, p. v, lines 193-209.

principles and questions of biomedical ethics and health care in North America today.

E) Philosophical Themes: Life Style, Tolerance

Questions and thoughts regarding ethics as lifestyle have resurfaced in every interview. A few examples will suffice here to illustrate these thoughtful responses of the physicians:

Growing up in a rural Mennonite Church where only a small minority of members would have had more than a high school education, I don't recall ever discussing "ethics" or the term *per se*. Even in college I recall few discussions - and no courses - dedicated specifically to the discipline of ethics. On the other hand, the intellectual boundaries between theology, morals, and behaviour were virtually indistinguishable. Living one's faith every day of the week and every hour of the day were important teachings in the tradition. Therefore, the development and evolution of my ethical thinking was implicit.¹⁹⁸

Ethics? The thing we knew was not to have sexual affairs. Is that ethics? I mean, how to live, there were certain behavioural things that we were taught?¹⁹⁹

[Ethics] is part of everything. But then in college we took an ethics course, that spelled it out, we verbalised the things that I just did. The course made it more solid, spelled it out... Certain amounts of ethics is just being a good moral person. But I think the Christian principles grow from the Bible, especially when we look at the Sermon on the Mount, that sort of thing, which I heard all the way through, but I think it was more solidified at college. I think it was called Christian Ethics, it was biblical based. Well, maybe in a secular school you get logical ethics. I say the course was called Christian Ethics, because that's the school you went to, and that's what I got. I can't divide ethics from everyday life.²⁰⁰

In these excerpts it is obvious again that in this theological understanding, ethics seems to be derived directly from scripture, especially the Sermon on the Mount. It seems interpreted by the believing community, and adopted by the individual by embodying such an ethic in his or her life.

We didn't think about it [ethics]. I would not have thought about it. Ethics was what you sort of knew [what] you should do and did [it]. In college I took a semester of philosophy and one on ethics. But I still, when I talk about ethics I have to stop and think. I don't know when I would have started to think ethics. Early on it would not have been a conscious thought, I don't think. When I started to think about the things I have been taught about growing up would have been in college. Up until college much of my church

¹⁹⁸ Interview # 1, p. i-ii, lines 37-44.

¹⁹⁹ Interview # 8, p. i, lines 32-33.

²⁰⁰ Interview # 9, p. ii, lines 48-50, 53-60.

and home life in relation to the church had to do with being ok, with being accepted by God primarily.²⁰¹

Faith, theological reasoning, and ethical embodiment, to which this physician was exposed, are observed, participated in, and embodied in his personal life. Because he or she has decided to appropriate this particular kind of ethical reasoning in their own lives, they are also ready to conceptualise this reasoning in their medical practice. One physician also mentioned the historical Anabaptist/Mennonite tradition of tolerance.

And I think Anabaptist is, the real Anabaptism going back to the 16th century, there was that strict tolerance... Whatever you do whether its Ginko or whatever is kind of minor in the faith relation. So tolerance is kind of not being judgemental, especially the right wing. Lot of Mennonites who don't know their heritage theologically are pretty intolerant.²⁰²

Other physicians implied an understanding of tolerance in cases of controversial decisions. Most of them seem to be willing to stretch traditional Mennonite theological teaching in favour of keeping the relationship with their patients. Maintaining the relationship with the patient superseded political correctness according to the churches' rules, so to speak. In many of the interviews, the Christian Medical and Dental Association in the USA was the focus of significant criticism for being too dogmatic about pro-life issues particularly, thereby jeopardising the doctor-patient relationship. For the Mennonite physician, however, keeping the relationship with the patient is paramount to being 'right' about a biomedical decision. The following illustration will help to clarify this point.

And you're trying to be a caring, supportive person in a place where you're saying, terminating the pregnancy is not right either. I have seen some pregnancy out of rape situations. I've had the dilemma of a 42 year old lady who had a Down's syndrome child and wanting to terminate. And also a person with a Down's syndrome child who would never think of termination. So I think that whole issue of how am I a physician as a caring supportive person to my patient who is wanting to make a decision but I'm really not comfortable with... My patients know where I stand, I've often told them that I would support them as a person but would not necessarily support their choice but I would not terminate my relationship with them.²⁰³

Summary of Interview Excerpts

It appears that Mennonite physicians have conceptualised Anabaptist/Mennonite theology into guiding principles for their medical practice.

²⁰¹ Interview # 6, p. ii, lines 72-80.

²⁰² Interview # 4, p. viii, lines 338-340, 345-348..

²⁰³ Interview # 2, p. v, lines 185-195.

These theological concepts of servanthood, peace and non-violent justice, and community are not generally opposed to professional codes of conduct or ethics. However, the question concerning the individual physician's action in instances of diverging opinions where he/she might have to choose between his/her theological conviction and professional ethics codes seems to be an important one. At this point, the data does not allow speculation about whether, or how often, the Mennonite physician has come up against such a 'principle' decision. Nevertheless, it seems safe to assume that the future might hold increasing tensions if Mennonite physicians become more actively involved in effecting change in the American health care system. Introducing Mennonite principles into health care might help to shift the focus from an individualist model of decision-making in biomedical ethics to a more communitarian model of decision-making processing. In order to know what kind of principles an Anabaptist/Mennonite biomedical ethics represents, we now need to analyse the interviews and extrapolate workable principles.

II. Interview Analysis

A) Coding

According to Grounded Theory approach, word based, qualitative interview analysis happens by letting the interview material 'speak' and then working with the emerging themes.²⁰⁴ In the process of reading the interviews, a coding list with three main categories was created. The categories are I) theological issues, II) ethical issues in medicine, and III) philosophical issues; philosophical is used to denote the process of thinking, which is unconnected with any philosophical school of thought. The complete coding list is on page ix in Appendix A. Because this dissertation is concerned with qualitative research based on a biographical-narrative model, the Grounded Theory approach was an emerging choice for analysis. The coding list emerged while the researcher took note of re-appearing themes in the interviews. These re-appearing themes have been listed in the thematically appropriate categories. In this way, control over the material was relinquished and trust in emerging themes was established. "Forcing and testing is not discovery, emergence is," says Barney Glaser in his discussion about Grounded Theory.²⁰⁵

²⁰⁴ Glaser, *Basics of Grounded Theory Analysis*. Chapter 7: "Open Coding", 38-48.

²⁰⁵ Glaser, *Basics of Grounded Theory Analysis*. 89-90.

B) Analysing: Theological Content

1. Servanthood as *model* for the Physicians

While analysing the interviews, the researcher found service and stewardship always mentioned together, just as caring and compassion are linked by the respondents. Questions arose to probe the significant meaning of servanthood in Mennonite understanding. Why do Mennonite physicians lay so much emphasis on servanthood? What is it specifically and how did they acquire such a thinking that seems to shape their work in medicine so profoundly? How do service, stewardship, caring and compassion support the idea of servanthood? Moreover, how can servanthood be applied in the praxis of medical ethics? It is critical to seek answers to these questions in the process of uncovering the meaning of servanthood, for in them are hidden the scripts for the construction of an Anabaptist Medical Ethics.

The concept of servanthood contains several important characteristics in Anabaptist/Mennonite theology such as stewardship, service, caring, and compassion. Those characteristics developed in Mennonite thought in several ways: one is the historical development of the Anabaptist/Mennonite movement, in which service, caring and compassion were crucial for the survival of the movement; the other development is Anabaptist theology's emphasis on service, caring and compassion as a person's practical expressions of faith. In the 16th century, after the Anabaptist movement had severed its ties with the magisterial church of the reformer Zwingli in Zurich, their reliance on each other for physical and spiritual survival was the most pressing issue.²⁰⁶ Out of this necessity, a complex support system developed which sustained the Anabaptist movement and the Mennonite churches through the centuries. Today, servanthood is still one of the more readily accepted characteristics of Mennonites, even though the emphasis on service, stewardship, caring and compassion can be used interchangeably, depending on a given situation.²⁰⁷

In addition, we find the questions of *personal integrity* and *moral responsibility* of the physician to the patient and how to appropriately apply the doctor-patient relationship. This quest beckons other questions pertinent to any physician, but especially the Christian physician, namely, where are the boundaries and limits in the relationship with the patient? In other words, what does it mean for the Mennonite physician 'to go the second mile' (Matt. 6:40), and when does going

²⁰⁶ For a summary of Anabaptist movement see Harold S. Bender *The Anabaptist Vision*, (Scottsdale, PA: Herald Press, 1944) and Guy F. Hersherberger *The Recovery of the Anabaptist Vision* (Scottsdale, PA: Herald Press, 1957).

²⁰⁷ Cf. Peachy, Laban. ME: Vol. V. "Stewardship", 858-859.

the second mile violate the doctor-patient relationship? Following on from here another question needs answering. What should a physician do when the patient worships in the same church community? Is it a professional indiscretion when the physician answers a question, innocently asked by the patient over Sunday morning coffee? Is the physician always the one who is more responsible than the patient for not violating the physician-patient relationship? If servanthood is the model for Mennonite physicians, where does the servant find his or her emotional and spiritual support system?

Several important points have been mentioned by the volunteers which substantiate the issues around servanthood. Those points can be summarised under the term *personal conduct*. There is the physician's personal responsibility before God in his/her practice as a physician. It seems as if the physicians univocally stated that for Mennonite physicians responsible ethical behaviour is paramount to their calling into this profession.²⁰⁸ Connected with personal responsibility we also find questions of life style, and about simple living. Interestingly though, the issues mentioned often seem related to the theological concept of the priesthood of all believers.²⁰⁹

2. Peace and Non-Violent Justice as *modus operandi* for Servanthood

Peace non-violence, and justice were terms which were used in the interviews to describe what the physicians see missing in their practice. The main emphasis was on justice, on just access in health care, and on questions of the millions of uninsured citizens in the USA. The questions were reflected upon first from a theological/faith perspective. Anabaptist/Mennonite theology of peace, justice, and non-violence was almost palpable in the responses to the questions.²¹⁰ It is interesting to observe that every single respondent who discussed justice and peace in relation to access in health care, also reflected on it in light of their personal high earning power. This seems to be a continuous issue with all of them, especially in light of the Anabaptist/Mennonite history and theology of simple living. The discrepancy between what the physicians have and what most people they work with can afford makes them uneasy; and most of them contend that it should make them very uneasy.

It is interesting to observe that there is a different emphasis on justice from the two Canadian volunteers than from their American counterparts. Justice in and

²⁰⁸ Interview # 1, p. iii, line 115; Interview # 2, p. viii, lines 336-345;

²⁰⁹ Interview # 2, p. vi, lines 235-265; Interview # 7, p. v-vi, lines 214-231; Interview # 8, p. ii-iii, lines 82-95.

²¹⁰ Interview # 1, p. i, lines 46-47;

access to health care does not seem to be such a pressing issues in Canada which attempts a universalised health care system. However, both of them are acutely aware of their fellow American physicians' problems with reimbursement for medical treatment.

3. Community as *Forum* for Servanthood and Peace and non-violent Justice

Again, the interpretation of community needs to be understood in a historical and theological framework. From the 16th century onward, community was essential for the physical, spiritual, and emotional survival of the individual. The theological interpretation of Believers baptism had ecclesiological consequences for the early Anabaptist. Denouncing infant baptism equalled heresy in the 16th century, resulting in simultaneous and instant expulsion from the Christendom churches, both Roman-Catholic and Reformed. It is not for this dissertation to decide whether the ecclesial understanding - the church is the beginning of the Kingdom of God on earth and therefore follows the laws of Christ first and the rules of Caesar second - is a consequence of Believers baptism, or whether it all began the other way around. It is important here to note that community formation and church understanding are essential features in the Mennonite physicians' interviews. Community seems to have several important attributes that the physicians want to see better incorporated into their medical practices.

By the way the physicians described their up-bringing, such as the influence of church teachings, important people and role models, and observing family members in the same profession, it seems that Anabaptist/Mennonite theology operates on a similar model as the participant-observation model in social theory. All of the physicians seemed to follow a similar path. Initially, they observed what happened in the church community. Then after a certain age there seems to have been selective participation in the church. After a period of participant observation a time of *embodying* followed. This period of embodiment seemed to happen for most of them during their college education.²¹¹ After this participant observation period and owning time, there followed the time of embodying their convictions. From the demographic data of the interview volunteers we can see that seven out of ten did voluntary work as physicians or as medical students. Such voluntary service assignments seem to have been formative experiences in all their lives because the

²¹¹ Interview # 1, p. i, lines 31-33; Interview # 6, p. iii, lines 106-113; Interview # 7, p. i, lines 36-39; Interview # 8, p. i, lines 32-42; Interview # 9, p. i, lines 25-32, 53-60; Interview # 10, p. i, lines 25-32.

physicians refer to them often in the interviews. Two of the physicians are still involved in volunteer work as physicians. It seems that this period of embodying their convictions was an important stepping stone for their future careers, and for their active involvement in MMA.

The unique combination of emphases on servanthood, peace and non-violent justice, and community could become the most pronounced feature of an Anabaptist/Mennonite Medical Ethics. How one relates these concepts in practical cases of biomedical ethics will be outlined in the last chapter. However, these three features are part of a strong ethos in Anabaptist/Mennonite history, past and present. Many Mennonite relief and educational agencies are based on the same features of servanthood, community, and peace and non-violent justice. Because the Mennonite physician emphasises all three of these features in his or her ethical reasoning, he or she has some difficulty in being issue-driven in biomedical ethics. For these physicians primary importance is put on integrity, character, and virtue; in other words, to know what kind of person one is, and then to practise one's profession with authenticity and integrity.

C) Analysing: Philosophical Content

The philosophical issues in Anabaptist/Mennonite perspective can chiefly be summarised by two guiding questions: one important question for the Mennonite physician is, can I separate my ethics from my theological convictions? Or put in a statement, as a Mennonite I believe my ethics can be observed in my lifestyle. Consequently, the second question is, if I as a physician with a particular theological conviction and ethical practice treat a patient with a diametrically opposed conviction and ethic, how supportive can I/should I be with the patient's choice even though we disagree? For the Mennonite physician, the question of faith conviction and patient support are inseparable. The interviews seem to show that the first question constantly challenges the theoretical reflections of the physician, whereas the second question seems to inform the more practical side of work. In all of the interviews, there appears an overwhelming sense that the Anabaptist/Mennonite physician cannot separate the theoretical, or theological-ethical part, of his or her work from its practical application.

It is interesting to observe that the above questions seem to be answered often by contrasting 'us' Mennonite physicians with 'them', that is, other evangelical physicians who are members of the CMDS in the USA. The Mennonite physicians do not appear to be overly dogmatic in questions of abortion or euthanasia. On the

contrary, it seems that there is very nuanced reasoning as to why one should not/cannot be dogmatic in some cases.²¹² Similar examples have already been found in both pilot study interviews. Both volunteers there were very dissatisfied with what they considered the limiting perspective of theology in biomedical ethics. This Anabaptist/Mennonite emphasis can be traced back to the issue of tolerance which has been discussed above in section one of this chapter.

It appears that particularly in this category of philosophical issues, the physicians refuse to be theologically or ethically pigeonholed. They do not want to be dogmatic about the 'right' application of scripture or theology, while at the same time they also do not want to lose the focus on following Jesus in their daily lives as physicians. We find again the close symbiosis between the interpretive community and the individual, where the community calls the individual to faithful discipleship.²¹³ We can follow Richard Hays' reasoning back to Barth, who wrote in his German edition of *Kirchliche Dogmatik* that

where God is understood as the Lord of humanity, there humanity is also confronted with the problem of obedience. The problem of obedience, however, is also the problem of human action or doing. And it is here where dogmatic merges with the problem of ethics.²¹⁴

Barth connects human action directly with humanity's obedience to the Lordship of God and states that in the merger of human action and dogmatic ethics happens. This he also calls "the existential human problem because existing as human beings means to take action".²¹⁵

The question of human action is also a burning question for the Mennonite physicians. It appears that this Chapter of interview analysis has supported the search for Anabaptist/Mennonite principles for biomedical ethics. However, before we can engage in applying such Anabaptist/Mennonite principles to issues in biomedical ethics, we need to understand more about the theology that carries and substantiates such claims.

²¹² Interview # 4, p. vii, lines 268-295; Interview # 2, p. vi, lines 255-280; Interview # 7, p. v-vi, lines 214-231.

²¹³ Cf. Richard B. Hayes. *The Moral Vision of the New Testament: A Contemporary Introduction to New Testament Ethics* (San Francisco: Harper San Francisco, 1996).

²¹⁴ Barth. *Die Kirchliche Dogmatik*. 594. (translation by the researcher).

²¹⁵ Barth, *Kirchliche Dogmatik*. 594.

Conclusion to the Chapter

In this chapter we have been introduced to excerpts of the interviews and to the process of analysing the interviews. The emerging themes have been summarised under three distinct headings. First there is servanthood that can be taken as a model for physician conduct. Secondly, we found that the physicians emphasised peace and non-violent justice as the *modus operandi* for such physician conduct. And thirdly, we found that it is the faith community in which the physicians have first learned about and experienced servanthood, peace and non-violent justice.

We also found an interesting pattern of learning to which the physicians have been exposed. The learning occurs in a pattern similar to a participant observation model. But in the case of the Anabaptist/Mennonite physicians, this model seems to be through the process of embodiment.

After this introduction to the empirical research, we now need to understand more about Anabaptist/Mennonite theology and ethics. This understanding will help us towards the completion of the thesis of this dissertation, namely that there are indeed unique contributions that Anabaptist/Mennonite theology can make to contemporary biomedical ethics. Because there would be a span of almost 500 years of theology to cover, we will select the current *Confession of Faith in a Mennonite Perspective* to compare the empirical findings with Anabaptist/Mennonite theology and ethics.

CHAPTER IV

ANABAPTIST THEOLOGY AND ETHICS

Introduction to the Chapter

As we have seen in Chapter I, Catholic moral theology and Protestant theological ethics are active and important voices in contemporary biomedical ethics. However, it seems that non-mainstream theologies only play minor roles in this emerging field. Chapter II has introduced us to the empirical research among Anabaptist/Mennonite physicians. In the analysis of the interviews in Chapter III, we have found that the physicians put great emphasis on theological concepts that have not been used in other theological approaches to biomedical ethics so far. Servanthood, peace and non-violent justice, and community seem to be specific theological expressions that result from Anabaptist/Mennonite theology. Why these particular theological issues are interesting for the physician needs to be examined in our current chapter. Since this dissertation argues for the inclusion of Anabaptist/Mennonite theology in biomedical ethics discourse, it is now the burden of Chapter IV to investigate this theological and ethical approach and provide a rationale for the research analysis of the previous chapter.

This chapter carries a double burden. On one hand it will connect Anabaptist/Mennonite theology with Christian virtue ethics as we discussed it previously in Chapter I. On the other hand, it will provide us on the necessary theological and ethical concepts for the following discussion with the thoughts of John Howard Yoder in Chapter IV. Yoder's discussion will prepare the way for our final chapter where we need to apply the Anabaptist/Mennonite principles of servanthood, peace and non-violent justice, and community to the discussion on current issues in contemporary biomedical ethics.

Chapter I of this dissertation has shown that theological scholarship of the Catholic and mainstream Protestant churches has been at the heart of early biomedical ethics, but finds itself marginalized today from much of current discourse in biomedical ethics. This chapter will argue that theology needs to be included again in the discourse on biomedical ethics and it will show that the voice of Radical Reformation theology in particular provides vital theological contributions to contemporary biomedical ethics that should not be overlooked any longer. This chapter will demonstrate that in Anabaptist/Mennonite theology it is impossible to

divide theology from ethics. The ethical behaviour and conviction of Mennonites is inextricably linked with theological or faith convictions. Therefore, if one wants to come to an ethical decision one has to argue that decision from a theological, and in the case of this dissertation, Mennonite perspective.

We will first discuss several theological concepts that are intrinsically important to Anabaptist/Mennonite theological understanding. These concepts are the Community of Believers, the hermeneutical circle, and the connection between observation-participation and embodiment in conjunction with the formation of character. After this theoretical framework has been established, three important Anabaptist/Mennonite principles will have emerged: servanthood, peace and non-violent justice, and community. These principles are probably the key guidelines among most churches of the Anabaptist/Mennonite heritage.

In the second part of this chapter we will try to apply these guiding principles in Mennonite ethical practice. For more complete and in-depth conceptualising of the ideas proposed above, we will explicate supporting arguments from the thoughts of Mennonite historian and theologian John Howard Yoder.

I. COMMUNITY OF BELIEVERS IN ANABAPTIST THEOLOGY AND ETHICS

The concise Oxford Dictionary defines community as “a group of people living together in one place, especially one practising common ownership”.²¹⁶ Living together in one place has been true for many generations of Anabaptists, particularly those who lived in 18th and 19th century Prussia and Russia.²¹⁷ Practicing common ownership was not only crucial for their physical survival, Anabaptists have also taken the account of the early church in Acts 2 as a basis for their theological interpretation. But for Anabaptist/Mennonites, community is much more than living together, it has also been a necessary way of surviving physically and spiritually. Commonality in faith and theology, commonality in peace and justice, and commonality in community efforts can also be called “the condition of having certain attitudes and interests in common”.²¹⁸ Commonality by no means implies uniformity.

²¹⁶COD 2000, CD-ROM. “community”

²¹⁷Cf. John B. Toews, “Czars, Soviets and Mennonites”, MQR 59:94-98 Jan. 1985.

²¹⁸COD: “community”

The Anabaptist movement has never been a uniform movement; it has rather been a movement that consisted of groups of people who shared common features or attitudes.²¹⁹ Even though Mennonites are the focus of this dissertation, we need to be clear at this point that the early Anabaptist movement consisted not only of Mennonites.²²⁰ The term 'Anabaptist' generally encompasses all churches that practise Believers baptism. The compound noun Anabaptism derives its meaning from the Greek *ανα*, meaning over or again, and *βαπτισμο*, meaning baptism. Anabaptism particularly refers to the Believers Churches that understand themselves to be members of this group of traditional peace churches.²²¹ In a strict sense we could say that the term 'Anabaptist' was only valid for the first generation leaders, who were all baptised as infants. Anabaptists after the second generation tended not to be re-baptised since they had not received infant baptism at all.

For Mennonites of the Anabaptist tradition, with whom this dissertation is concerned, it has always been paramount to ground their beliefs and actions in the Old and New Testament. In theological discussions, such a hermeneutic has sometimes been to their detriment, leading to accusations of being too biblicistic.²²² Nonetheless, taking biblical Scripture as a starting point for the hermeneutic community in discernment and practice has not only provided Mennonite churches with the tools for community hermeneutics, the so-called hermeneutical circle, but has also had a strong influence on the theological construction of that very community.²²³ Is it therefore impossible to decide whether community came first and was then followed by hermeneutical practice, or, whether there was first biblical interpretation from which community resulted? For our purpose it would be

²¹⁹ James Stayer, W. Packhull, and K. Depperman, "From Monogenesis to Polygenesis: The Historical Discussion of Anabaptist Origins." *MQR* 49: 4 (1975): 83-86.

²²⁰ Hofer, John, Hans Meier, and John V. Hinde, "Hutterian Brethren", in *ME*: Vol. V: 406-409. Hutterites and various groups of Amish belong to the larger Anabaptist family as well. The *Chronicle of the Hutterites*, printed in 1665 is the main record of persecution among the Hutterite communities. Hutterian Brethren. *Brothers Unite*. Rifton, NY: Plough Publishing House, 1988. Cf. Hans, J. Hillerbrand, *Quellen zur Geschichte der Täufer, Vol.X. Bibliographie der Täuferturns 1520-1630*. Guethersloher Verlagshaus, 1962.

Cf. Steiner, Sam, *ME*: Vol. V. "Amish", 20-22. The Old Order Amish should not be confused with the Amish Mennonites who are making up a large part of the Mennonite Church USA today.

²²¹ Included in the Believers Churches are Mennonites of all shades, Brethren in Christ and Church of the Brethren. Cf. William Brackney, H., *The Believers Church: A Voluntary Church* (Kitchener, ON: Pandora Press, 1998). Barry Callen, L., *Radical Christianity: The Believers Church Tradition in Christianity's History and Future* (Nappanee, IN: Evangel Publishing House, 1999). Stewart Murray, *Biblical Interpretation in the Anabaptist Tradition*, vol. 3, *Studies in the Believers Church Tradition* (Kitchener, ON: Pandora Press, 2000).

²²² Murray, *Biblical Interpretation in the Anabaptist Tradition*, 55.

²²³ Harder-Neufeld, *Obedience, Suspicion and the Gospel of Mark*. Introduction.

unnecessary and unwise to separate this symbiotic relationship; moreover, it is not the place of this dissertation to do that. What is important here, is to locate the influence which the confessions of faith have had (and still have) on the Mennonite community and on its hermeneutic and practice; by extension, we will also see what kind of influence the confessions have had on the concept of the individual as a member in his or her community.

We will now begin to investigate the influence of the *Confession of Faith in a Mennonite Perspective* on community hermeneutics and on theology and ethics; secondly we will look at church practice and its influences on character and identity formation. In the second part we will discuss the thoughts of current Mennonite scholarship in regard to Anabaptist/Mennonite theology and ethics.

A) Community Hermeneutics in Anabaptist Theology

In Anabaptist/Mennonite theology, community hermeneutics is inextricably linked with the confessions of faith. Space restrictions are not conducive to an in-depth study of all confessions written in the Anabaptist tradition,²²⁴ therefore we will only focus on the influence of the most recent one, the *Confession of Faith in a Mennonite Perspective*.²²⁵ Nonetheless, confessions of faith have been instrumental in the development of the Anabaptist movement for the following reasons.

1. The Forming Character of the Confessions

In Anabaptist theology, personal development is closely intertwined with the practice of community, not just with personal development in the family of origin. In early Anabaptism, the community of believers became for many individuals the first point of reference, particularly for the interpretation of scripture.²²⁶ Stuart Murray sees several distinguishing features in Anabaptist hermeneutic as instrumental in the formation of the largely confessional character of the Anabaptist/Mennonite movement. He contends that on one hand, the Anabaptists' insistence on the self-interpretation of the Bible and an unbreachable Christocentrism was the cause of violent persecution, but on the other hand these interpretations were also the centers around which the hermeneutic community gathered.²²⁷ This radical community

²²⁴ John Howard Yoder, *The Schleithem Confession* (Scottsdale, PA: Herald Press, 1977). Wenger, J. C. [*The Dordrecht*] *Confession of Faith*. (LaGrange, IN: Pathway Publishers, 1994). These two confessions are by no means singular examples. However, these two have been the most influential confessions in Mennonite perspective. Cf. Howard John Loewen, *One Lord, One Church, One Hope and One God*, Text-Reader Series No. 2. (Elkhart, IN: Institute of Mennonite Studies, 1985). For a full text copy of the Schleithem Confession and the Dordrecht Confession see Appendix B.

²²⁵ *Confession of Faith in a Mennonite Perspective*. Scottsdale, PA: Herald Press, 1995.

²²⁶ Murray, *Biblical Interpretation*. 161-161.

²²⁷ Murray, *Biblical Interpretation*. 82.

hermeneutic presupposed several ecclesiastical practices which were interpreted by the official reformers as heresies at the beginning of the Anabaptist movement: believers baptism, the Lord's Supper only for the members of the believing community, denouncement of warfare, and insistence that the Kingdom of God has already begun wherever the believers gather as an obedient community.²²⁸ With the denouncing of the radical Ecclesial actions of the early Anabaptists as heresies, a cycle of exclusion began for the young movement which eventually ended in widespread persecution and expulsion.²²⁹

Baptism on Confession of Faith: Believers Baptism

One of these contended issues was the equality of all believers which is practised in personal confession of faith and precedes believers baptism. Article 11 of the *Confession of Faith in Mennonite Perspective* reads as follows:

We believe that the baptism of believers with water is a sign of their cleansing from sin. Baptism is also a pledge before the church of their covenant with God to walk in the way of Jesus Christ through power of the Holy Spirit. Baptism is a testimony to God's gift of the Holy Spirit in the lives of believers. Through the Spirit we repent and turn toward God in faith. The baptism of the Holy Spirit enables believers to walk in newness of life, to live in community with Christ and the church, to offer Christ's healing and forgiveness to those in need, to witness boldly to the good news of Christ, and to hope in the sharing of God's future glory. Baptism by water is a sign that a person has repented, received forgiveness, renounced evil, and died to sin (Rom. 6:1-4)...Christian baptism is for those who confess their sins, repent, accept Jesus Christ as Savior and Lord and commit themselves to follow Christ in obedience as members of his body, both giving and receiving care and counsel in the church. Baptism is for those who are of the age of accountability and who freely request baptism on the basis of their response to Jesus Christ in faith (Math. 28:19; John 4:1; Acts 2:38; Gal. 3:27).²³⁰

This excerpt states that baptism is a sign of cleansing, testimony, and commitment to God and the church community. It is supposed to be preceded by the believer's confession of faith, repentance of sin, and acceptance of Christ's saving grace. Whether the early Anabaptists had any idea about the implications of their radical reading of, and obedience to Scripture, cannot be established here. Neither should we speculate at this point whether the early leaders already had a firm idea about the concept of the community that they were seeking. What we can establish, however, is that their radical step of denouncing the infant baptism of the Reformed

²²⁸ Guy Hersberger, F. *The Recovery of the Anabaptist Vision* (Scotsdale, PA: Herald Press, 1957). C. Norman Kraus, *God Our Saviour: Theology in a Christological Mode* (Scottsdale, PA: Herald Press, 1991).

²²⁹ Horsch, John *Mennonites in Europe*, (Scottsdale, PA: Mennonite Publishing House, 1950²).

²³⁰ *Confession of Faith*, 46-47.

church separated them from the established churches and made them religious and social outcasts.²³¹ In order to secure their physical as well as spiritual survival, the early Anabaptists had to rely on each other for physical, emotional, and spiritual support, thereby strengthening and establishing their concept of community.²³²

The Lord's Supper

The second issue of discontent with the Reformed Church of Zwingli was the administering of the Lord's Supper. Today as in early Anabaptist/Mennonite history,²³³ the Lord's Supper is "a sign of remembering the new covenant and renews our baptismal covenant with God and each other and recognises our unity with all believers everywhere and in all times".²³⁴ Here we see the symbiotic connection between the confessional interpretation and the practice of baptism and the Lord's Supper. In 16th century Switzerland, Southern Germany and Holland, however, the Anabaptist leaders criticised the leaders of the Reformed churches for taking the Lord's Supper in vain and administering it lightly, even to those members of the church who did not follow Christ in their daily life.²³⁵ Not only was it paramount for early Anabaptists to stress discipleship and right living after one has decided for the way of Christ, there was another, underlying issue which bothered the Reformers: the perceived non-sacramental use of the sacraments and the interpretation of Scriptures by uneducated and non-ordained ordinary people. Underlying the baptism disputation are two crucial issues: one is the doctrine of the sacramental nature of baptism, and the other is the socio-political registration of baptized citizens for tax purposes.²³⁶ By denying both the sacramental and saving nature of baptism which automatically registered everybody as citizens, Anabaptists were considered heretics and enemies of the state (which in Zwingli's Zurich, was the closest ally of the church), and by doing so, they inadvertently criticized the doctrine of grace, the very heart of the Protestant Reformation.

The Lord's Supper points to Jesus Christ, whose body was given for us and whose shed blood established the new covenant (Jer. 31:31-34; 1 Cor. 11:24-2). In sharing the bread and cup, each believer remembers the death of Jesus

²³¹ Egli, Emil. *Corpus Reformatorum, XCI. Huldreich Zwinglis Saemtliche Werke, Band IV*. (Leipzig: M. Heinsius Verlag, 1927) "Antwort ueber Balthasar Humaiers Taufbuechlein", 577-642. Cf. Walter Koehler. *Das Buch der Reformation Huldych Zwinglis*. (Muneechen: Ernst Reinhard Verlag, 1926).

²³² Cf. John. Horsch, *Mennonites in Europe*.

²³³ Cf. Article III in *The Schleithem Confession*, p. iii, and Article X in *The [Dordrecht] Confession of Faith.*, p. vx, Appendix B.

²³⁴ *Confession of Faith*. Article 12: "The Lord's Supper". 50.

²³⁵ Wenger, John. C. *The Complete Writings of Menno Simons*. Scotdale, PA: Herald Press, 1956. 333-334.

²³⁶ Egli, Emil. *Corpus Reformatorum*. 590-627.

and God's act of deliverance in raising Jesus from the dead. As we relive this event with a common meal, we give thanks for all God's acts of deliverance in the past and present, for the forgiveness of sins, and for God's continuing grace in our lives...All are invited to the Lord's table who have been baptized into the community of faith, are living at peace with God and with their brothers and sisters in the faith, and are willing to be accountable in their congregation. Celebrating the Lord's Supper in this manner, the church looks forward in joy and hope to the feast of the redeemed with Christ in the age to come (Luke 22:15-20; 28-30).²³⁷

In Anabaptist/Mennonite interpretation, only God's acts of deliverance and the grace of God in Christ's victory over death have saving power, not baptism and Lord's Supper in and by themselves. Here again we become aware of the threat this interpretation might have caused the established, Roman Catholic and Reformed Churches. By interpreting baptism and the Lord's Supper as signs rather than as saving sacraments, the early Anabaptists seem to have refused to acknowledge the authority of the established Churches as mediating agent between God and God's people.

Peace and Non-violence and Separation of Church and State

The third issue which pushed the early Anabaptists closer into community with each other, but farther to the margins of 16th century society, was the Anabaptists' insistence on denouncing warfare and on separating Church and State. Besides the issue of believers baptism, Anabaptists/Mennonites today are probably best known for their conviction on Peace, Justice, and Nonresistance (article 22), and their interpretation on The Church's Relations to Government and Society (article 23).²³⁸ The peace position of Mennonites has been discussed in many publications and was a driving force for many years during the Cold War and the Nuclear Arms Race of the 1980s.²³⁹ The interpretation on peace, justice and nonresistance in the Confession of Faith says that:

We believe that peace is the will of God. God created the world in peace, and God's peace is most fully revealed in Jesus Christ, who is our peace and the peace of the whole world. Led by the Holy Spirit, we follow Christ in the way of peace, doing justice, bringing reconciliation, and practising nonresistance even in the face of violence and warfare...As followers of Jesus, we participate in his ministry of peace and justice. He has called us to find our blessing in making peace and seeking justice. We do so in a spirit of gentleness, willing to be persecuted for righteousness' sake (Math. 5:3-12)...Led by the Spirit, and beginning in the church, we witness to all people

²³⁷ *Confession of Faith*, Article 12: "The Lords Supper". 50-51.

²³⁸ *Confession of Faith*. 81-84 and 85-88 respectively.

²³⁹ Snyder, Graydon, F. *Health and Medicine in the Anabaptist Tradition: Care in Community*. (Valley Forge, PA: Trinity Press International, 1995). 88.

that violence is not the will of God. We witness against all forms of violence, including war among nations, hostility among races and classes, abuse of children and women, violence between men and women, abortion, and capital punishment.

We give our ultimate loyalty to the God of grace and peace, who guides the church daily in overcoming evil with good, who empowers us to do justice, and who sustains is in the glorious hope of the peaceable reign of God (Isa. 11:1-9).²⁴⁰

It is within the community of believers that peace and nonviolence is practised first, because it is in the community of believers that Christ is experienced in baptism, Lord's Supper, and the discussion of Scripture. It is this sustaining power that then provides the resources to extend the peace of Christ to society at large. As we will see later in the chapter, witnessing is not only a verbal act, it is made concrete through many Mennonites who are actively involved against violence and war all over the world.²⁴¹ The way of peace and nonviolence is extended to us by Christ, who lived his life as an example for us to follow. Through historical experience it is clear for Anabaptist/Mennonites that this is not an easy way and not every Christian will interpret the life of Christ as they do; neither do all Christians emphasise peace, nonviolence, and non-resistance in the same way as many Mennonites do. In Mennonite theology, peace and nonviolence can never be had within the confines of societal human law, since human law is a human construction and therefore part of the fallen creation. Even though article 23 is rather long, we will find it quoted in entirety in order to clarify to what extent Anabaptist/Mennonite theology focuses its ecclesiology around the community of believers. To understand this connection is vital for the argument in this dissertation.

We believe that the church is God's "holy nation" (1 Peter 2:9), called to give full allegiance to Christ its head and to witness to all nations about God's saving love. The church is the spiritual, social, and political body that gives its allegiance to God alone. As citizens of God's kingdom (Phil. 3:20; Eph. 2:19), we trust in the power of God's love for our defence. The church knows no geographical boundaries and needs no violence for its protection. The only Christian nation is the church of Jesus Christ, made up of people from every tribe and nation (Rev. 7:9). called to witness to God's glory.

In contrast to the church, governing authorities of the world have been instituted by God for maintaining order in societies. Such governments and other human institutions as servants of God are called to act justly and provide order (Rom. 13:1-7). But like all such institutions, nations tend to

²⁴⁰ Snyder, *Health and Medicine in the Anabaptist Tradition*, 81-82.

²⁴¹ The Mennonite Central Committee has become instrumental in facilitation relief and peace work all over the world. Cf. <http://www.mcc.org/peacecommit.html>

demand total allegiance. They then become idolatrous and rebellious against the will of God (Daniel 7-8). Even at its best, a government cannot act completely according to the justice of God because no nation, except the church, confesses Christ's rule as its foundation. As Christians we are to respect those in authority and to pray for all people, including those in government, that they also may be saved and come to the knowledge of the truth (1 Tim. 2:1-4). We may participate in government or other institutions of society only in ways that do not violate the love and holiness taught by Christ and do not compromise our loyalty to Christ. We witness to the nations by being that "city on a hill" which demonstrates the way of Christ (Math. 5:13-16; Isa. 49:6). We also witness by being ambassadors for Christ (2 Cor. 5:20), calling the nations (and all persons and institutions) to move toward justice, peace and compassion for all people. In so doing we seek the welfare of the city to which God has sent us (Jer. 29:7).

We understand that Christ, by his death and resurrection, has won victory over the powers, including all governments (Col. 2:15). Because we confess that Jesus Christ has been exalted as Lord of lords, we recognise no other authority's claims as ultimate.²⁴²

Not only did early Anabaptists refuse to accept clergy as necessary mediators of God's grace in baptism and the Lord's Supper, they also denied any allegiance to anything humanly constructed, or any human authority if such authority does not take scriptures seriously. This point has been, and to some extent still is, a recurring point of contention with Mennonite Churches. We will shortly enter the discussion about the validity of such a separatist interpretation and try to find applications for such an approach to ecclesiology. The task here is to make the connection between Mennonite community hermeneutics and theological reasoning as put forth in the Confession of Faith.

Thus far we have been introduced to historical and ecclesiastical developments which led to the separation of early Anabaptists from the established Reformed Church. We have been introduced to the re-interpretation of baptism and the Lord's Supper, an interpretation that focuses away from their sacramental nature, but sees them as signs of God's grace. If these were internal, ecclesiastical reasons for Anabaptists to separate from the Reformed Church, then the external, outwards signs of that separation consequently had to be a physical separation from all authority, Church and State alike.²⁴³ J. Lawrence Burkholder finds this dualistic emphasis of Mennonite ecclesial practice "expressed socially in Anabaptism".²⁴⁴ In

²⁴² *Confession of Faith*. 85-86.

²⁴³ Cf. Yoder, *The Schleithem Confession*. Article VI. 14-16. See also *The [Dordrecht] Confession of Faith*. Articles XIII and XIV. 29-33.

²⁴⁴ Burkholder, J. Lawrence. *The Problem of Social Responsibility from the Perspective of the Mennonite Church*. (Elkhart, IN: Institute of Mennonite Studies, 1989). 107.

his understanding, the problem of separation and social responsibility was but a consequence of the early Anabaptists' obedience to scripture and their deep suspicion of worldly authority. He goes on to challenge Anabaptist/Mennonites today by questioning their attitude towards society which lets "government and responsibility for the world order fall into the hands of non-Christian people".²⁴⁵ His challenges need to be taken seriously, particularly in relation to the vast and explosively growing field of biomedical ethics, with which this dissertation is concerned.

Today's Mennonites do not seem to have the same separation problems in relation to the State; however, the confession clearly admonishes that first allegiance belongs to God who has been revealed in the life, death, and resurrection of Christ. If state authority, or any other secular institution demands this place of allegiance, then a Mennonite Christian is asked to contemplate his or her priorities. For the construction of the community hermeneutics in Anabaptist/Mennonite understanding it is crucial to see the inextricable links between the following three elements. First, the community discovers the word of Scripture together by mutual interpretation. This leads, secondly, to the establishment of guidelines according to which the community decides to live, e.g. baptism, Lord's Supper, and separation of church and world authorities. In this second step we find that the community of believers come to decisions about discipleship and ethical conduct. At this point theological interpretation practice and ecclesial practice meet, decisions about further proceedings are made. In a third, consequent step, we find the hermeneutic community going back to scripture to see whether their theology and practice are still in accordance with the Scriptures, which they hold to be true. The intended result of this type of reasoning, which Hans-Georg Gadamer calls "die Zirkelstruktur des Verstehens,"²⁴⁶ (the circular structure of understanding), is that the hermeneutic community is continually challenged to evaluate their practice in light of theology in order to uncover blind spots. Gadamer calls this a result or consequence that attempts "to rectify or correct the self-understanding of the always practised understanding".²⁴⁷

Conceptual Framework of Terms

The terms which are chosen for the sake of this dissertation convey the same meaning but they are easier to understand and more versatile in their application.

²⁴⁵ Burkholder, *The Problem of Social Responsibility*. 116.

²⁴⁶ Gadamer, Hans-Georg. *Wahrheit und Methode: Grundzuege einer philosophischen Hermeneutik*. Tuebingen: J.C.B. Mohr Verlag, 1960. 250ff.

²⁴⁷ Gadamer, *Wahrheit und Methode*, 250.

First we will talk about *observation*. The definition of observation in the Concise Oxford Dictionary is “taking the sun’s or another celestial body’s altitude to find a latitude or longitude”, and “a comment based on something one has seen, heard, or noticed”.²⁴⁸ In Anabaptist observation scripture is used as a measure to discern the churches latitude for her work and service in the world; observation happens within and by the community and requires the participatory input of all individual members. However, observation can also mean a passive observing, a standing by, a watching or taking in, until one is ready for action.

Participation will mean actively taking part in the hermeneutic community by sharing and contributing ones ideas and initiatives for the common good. This term will be used in the best sense of its Latin origin *pars carpere*, to part- take or share in.²⁴⁹ Participant observation is based on the individual’s watching and observing while coming to a decision whether he/she wants to be part of such community. Finally, observation and participation will result in *embodiment* of one’s conviction. This is a necessary third step if the hermeneutic community truly wants to be an agent of change. During observation, participation, and embodiment, the individual and the community need to constantly be aware of the scriptural requirements for such a theology in practice. This observation of scripture and participation in the hermeneutic community are essential elements in this understanding of the community. To verify this theoretical claim, we will now have to observe how the Anabaptist/Mennonite community has put its concept of the hermeneutic community to work on applying the confession in praxis.

2. Applying the Confession in Anabaptist Praxis

According to the *Confession of Faith in a Mennonite Perspective*, applying faith happens in three areas: in the private lives of individuals (Articles 17-19), in the gathered church community (articles 14-16) and in the community at large (article 21). Articles 22 and 23 also belong to this category, but they have already been discussed above.

Article 17 of the *Confession* encourages the individual to lead a righteous life according to the example of Christ, which in Mennonite thought necessarily means nonconformity to the world.

Conformity to Christ necessarily implies nonconformity to the world (Rom. 12:1-2). True faith in Christ means willingness to do the will of God, rather

²⁴⁸ COD: “Observation”.

²⁴⁹ COD: “Participation”.

than willful pursuit of individual happiness (Math.. 26:39). True faith means seeking first the reign of God in simplicity, rather than pursuing materialism (Math. 5:3; 6:25-33). True faith means acting in peace and justice rather than with violence or military means (Zech. 4:6; Math. 5:6; 9:38-48). True faith means giving first loyalty to God's kingdom, rather than to any nation-state or ethnic group that claims allegiance (Josh. 24; Acts 5:29). True faith means honest affirmation of the truth, rather than reliance on oaths to guarantee our truth telling (Math. 5:33-37.... True faith means treating our bodies as God's temples, rather than allowing addictive behaviours to take hold. True faith mean performing deeds of compassion and reconciliation, in holiness of life, instead of letting sin rule over us (Micah 6:8; Rom. 6:12-14). Our faithfulness is lived out in the loving life and witness of the church community which is to be a separate people, holy to God.

In all areas of life, we are called to be Jesus' disciples. Jesus is our example, especially in his suffering for the right without retaliation, in his love for enemies and in his forgiveness of those who persecuted him.

In this article all areas of life are considered. As discussed above, particular stress is laid on 'over-againstness' of the Christian in relation to the world. We also find here particular attention to simplicity, healthy or holistic living, compassion, and reconciliation. Living a non-conforming, simple, and holistic life is what many people seek. For Mennonites of the last two centuries this way of life might have been more easily accomplished, because simplicity has often been synonymous with an agrarian life style. Burkholder contends that because Mennonites have stressed literal New Testament application to their private and communal discipleship "agrarianism has been the most determinate factor of the life of Mennonite communities".²⁵⁰ In-depth historical and sociological studies might indeed support him in this assumption, and even a cursory reading of Mennonite history will point the reader towards the significant land-boundness of Anabaptist/Mennonites. Such land boundness affects many factors, including social, historical, economic, and not least, ecclesial. As we have seen above, the confessions of faith have had a major impact on the private and social theology of an entire movement. The *Confession of Faith in a Mennonite Perspective* is an important agent of formation of the community, but how is it applied in the 21st century, in which Mennonite communities are increasingly urbanised? Will an upwardly mobile Mennonite community be able to incorporate simplicity, non-conformity, peace and justice into their professional and social contexts?

Article 21 on Christian Stewardship in the *Confession of Faith* is crucial in the application of Mennonite theology, not only within the boundaries of the

²⁵⁰ Burkholder, *The Problem of Social Responsibility*. 133.

community, but in society at large as well. It is in this article that the confessional theory has to become praxis in order to maintain its viability. It is in this article that observation becomes application, or, as Gadamer calls it, the place where “das Selbstverstaendnis des stets geuebtten Verstehens berichtigt wird”.²⁵¹ For the Anabaptist/Mennonite that means faith and theology have to become embodied in real life situations.

We believe that everything belongs to God, who calls us as the church to live as faithful stewards of all that God has entrusted to us.

As servants of God, our primary vocation is to be stewards in God’s household (Lk. 12:38-45). God, who in Christ has given us new life, has also given us spiritual gifts to use for the church’s nurture and mission (1 Peter 4:10-11; Tit. 1:7; 2:5). The message of reconciliation has been entrusted to every believer, so that through the church the mystery of the gospel might be made known to the world (2 Cor. 5:18-20; Eph. 3:1-10)... We believe that time also belongs to God and that we are to use with care the time of which we are stewards (Col. 4:5-6).

We acknowledge that God as Creator is owner of all things. In the Old Testament, the Sabbath year and the Jubilee year were practical expressions of the belief that the land is God’s and the people of Israel belong to God. Jesus, at the beginning of his ministry, announced the year of the Lord’s favour, often identified with Jubilee. Through Jesus, the poor heard the good news, captives were released, and blind saw, and the oppressed went free (Luke 4:16-21). The first church in Jerusalem put Jubilee into practice by preaching the gospel, healing the sick, and sharing possessions. Other early churches shared financially with those in need (Acts 2:44-45; 4:32-37).

As stewards of God’s earth, we are called to care for the earth and to bring rest and renewal to the land and everything that lives in it (Gen. 1: 26-28). As stewards of money and possessions, we are to live simply, practise mutual aid within the church, uphold economic justice, and give generously and cheerfully (Phil 4:11-12; 2 Cor. 8:13-14; James 5:4). As persons dependent on God’s providence, we are not to be anxious about the necessities of life, but to seek first the kingdom of God (Matt. 6: 24-33). We cannot be true servants of God and let our lives be ruled by desires for wealth.

We are called to be stewards of God in the household of God, set apart for the service of God. We live out now the rest and justice which God has promised (Matt. 11:28-29; Rev. 7:15-17).²⁵²

Stewardship of money and possessions, simple living, mutual aid, economic justice, charity (generous giving), and stewardship as expressions of service to God

²⁵¹ Gadamer, *Wahrheit und Methode*. 250.

²⁵² *Confession of Faith*. Article 21: Christian Stewardship. 77-80. It is important to mention that neither The Schleithem Confession nor the Dordrecht Confession of Faith specifically mention stewardship in a separate article. However, by way of emphasis on Jesus as our model for living it is implied throughout both confessions.

are the prime objects for Anabaptist/Mennonites to engage in as a result of their faith decision. In their practice and careers faith and theology are to be revealed. This admonition of the *Confession of Faith* has been followed over many years in many different ways, particularly in the area of education, medicine, and relief work all over the world.²⁵³ It is not the focus of this dissertation to highlight all the work done by many different Mennonite groups all over the world; this has been done elsewhere to a great extent.²⁵⁴ The burden of this chapter is to outline the impact of one's faith and theology on one's practical behaviour.

Discipleship

In the case of Anabaptist/Mennonite theology, the major emphasis is on discipleship. Discipleship in a Mennonite context means that a Christian responds to the claim Christ makes on him or her, like the disciples and the early church.²⁵⁵ Responding in this manner, Anabaptist/Mennonites have put significant importance on reading and interpreting Scripture together, sharing the signs of God's redeeming love in baptism and the Lord's Supper, and supporting each other in community. Embodiment of faith is greatly stressed all through Anabaptist/Mennonite history. The interpretation of James 2, 'working out one's faith', has been one of the primary examples of how to integrate faith and praxis (James 1:19-27). However, this approach to discipleship has also introduced a few complications, especially for Mennonites in the 21st century. While many Mennonites may sociologically move away from the country, away from agrarian lifestyle and close community, they also move away from simple life, primary relationships, and certain sets of reasoning; they encounter an intellectual 'new land', so to speak. Urbanisation, and particularly professionalisation, have put many Mennonites into the new land of multiple sets of reasoning, multilateral relationships and complicated lives. Burkholder explains this move from the country to the city as follows:

²⁵³ www.mcc.org.

²⁵⁴ Neufeld, Elmer, "Mennonite Central Committee" (*International*). ME: Vol. V, 560-561.

<http://www.mcc.org/workbook/1999/10452.html>

Cf. Kreider, Robert. "The Impact of MCC Service on American Mennonites". MQR 44:245-261. 1970. 245. For MEDA cf. ME: Vol. V. "Mennonite Economic Development Associates", 570. Cf. <http://www.meda.org/>

This website gives a detailed account of projects and mission statements of MEDA and its partner organisations. For MDS cf. ME: Vol. V. "Disaster Service" 237-238. <http://www.mds.mennonite.net> For a detailed listing of educational institutions see ME: Vol. V. "Education" 259-261. "Scholarship" 799. "Seminaries" 809-811. In addition see the web site of Mennonite Central Committee <http://www.mcc.org> and the site of the Mennonite World Conference at <http://mwc-cmm.org>

²⁵⁵ Burkholder, *The Problem of Social Responsibility*. 93.

In this response [discipleship] the total life of the Christian is surrendered in a way which bring the inner disposition and the outward act together. Therefore, in Anabaptism, faith and ethics lie extremely close together. They are distinguishable but inseparable....The uniqueness of discipleship for Christian ethics in general and for social responsibility in particular lies in the fact that no appeal from philosophy or history is permitted to qualify the terms of obedience to Christ....The strenuous commands of Christ are held to be historically obligatory and possible. [Therefore] [a]ll alien sources of moral guidance which in any way tend to lower the level of Christian duty from the substance and the form of Christ's commands are either ignored or deliberately rejected...In the last analysis, Anabaptism stands for the earliest and most simple approach to Christian duty, namely, that which issues directly from the life and teaching of the historical Jesus as the Incarnate Lord."²⁵⁶

How will Mennonites of the 21st century be able to integrate their theology of discipleship and obedience with the demands of post-modern fragmented reasoning without violating any of these challenges and thereby losing their integrity?

Moreover, how will Mennonite physicians be able to integrate their faith perspective with its practical ethics with the demands of multilateral physician relationships?

Which, if any, principles might arise from such a theological approach to church, and how can these principles contribute to the current conversation in biomedical ethics?

Before we can answer these questions, we will investigate the three steps *observation, participation and embodiment*, and see how three Mennonite physicians have tried to make sense of their confessional theology in medical practice.

B. Formation of Identity and Character through Church Practice

So far we have established that Anabaptist/Mennonite church practice is closely intertwined with the *Confession of Faith*. We have also seen that the current *Confession of Faith in a Mennonite Perspective* (1995) is contingent on previous confessions, such as the *Schleitheim Confession* (1527) and *The [Dordrecht] Confession of Faith* (1632). In addition we have been made aware that by emphasising the various confessions, a particular approach to hermeneutic became important in Anabaptist/Mennonite theology, namely community hermeneutic. Community hermeneutic means that the community comes together for discussion and discernment around Scripture. After these deliberations, the community proceeds to practise what they have discerned. After practical application, the community comes back together to discern the theory again through the eyes of practice. For the purpose of this dissertation, these steps have been called *observation, participation,*

²⁵⁶ Burkholder, *The Problem of Social Responsibility*. 93-94.

and embodiment. These distinct, but inter-related steps will now be investigated more closely to see how, and to what extent, Anabaptist/Mennonite theology can be practically applied. For each step we have chosen a different interviewee, one to highlight observation, one for participation, and one for embodiment. We should be clear, however, that the dividing lines between these three steps are not always clearly demarked. After all, what we are discussing here is a hermeneutical circle practised in the Anabaptist/Mennonite community. By definition, a circle has neither beginning nor end. Likewise, in the Anabaptist/Mennonite hermeneutic community, the term hermeneutical circle encompasses observation, participation and embodiment, and in practice it is often difficult to know when one step ends and the next begins. The artificial and theoretical division of the circle into these three steps has been done for the sake of this dissertation.

1. Observation

There are several ways of interpreting observation. One is to observe or watch something closely, monitor and have the ability to notice significant details. Observation can therefore be the process of taking a fixed measure to find one's position. In the previous section we have seen that Anabaptist/Mennonites have taken scripture as their measure for interpersonal conduct and community organisation. Another interpretation is, however, that one can make an observation, in the sense that one can contribute to a discussion, although ideally this act of verbal observation has to be preceded by observation in the sense of watching something or someone.

The strong emphasis on service that was a repetitive theme in our local Mennonite Church certainly supported my interest in the medical profession. ... I suspect my early interest was heavily influenced by family discussions about [it] and with an uncle who was in medical school at the time, and an aunt who was a nurse. Since my uncle and aunt grew up in a Mennonite Church, I suspect discussions were influence significantly by that cultural and moral milieu.²⁵⁷

In this first interview excerpt we find the reference for ethical conduct primarily from within the theological framework of the interviewee. In addition to the teaching of the church. He also mentioned the lasting influence of reports by returning medical missionaries, which he was exposed to throughout his years of growing up in a Mennonite Church. One could dismiss these influences as adolescent infatuations. However, this interviewee goes on to say that

²⁵⁷ Interview # 1, p. i, lines 20-21, 13-17.

as a student, at Goshen College the more intense immersion in the Anabaptist Tradition and a strong sense of 'call', *vocare*, further confirmed my interest in and commitment to the medical profession.²⁵⁸

His observations of the practices in the Mennonite Church have led him to emphasise the following characteristics of Anabaptist/Mennonite theology:

Jesus is the Christ. Jesus is the touchstone, the norm for behaviour. Thus the Sermon on the Mount becomes the guideline for daily living, not an ideal for some future kingdom. Honesty and integrity in relationships, sanctity of life, non-resistance and pacifism, non-conformity, a high priority on church community and mutual caring, servant leadership, separation of church civic authority and evangelism through service.²⁵⁹

This physician grew up in a Mennonite Church. In fact he states in the demographic questionnaire that he had been a member of a Mennonite Church since 1940. This means he spend his youth and young adulthood under the nurturing influence of a caring community which supported his personal and spiritual growth. The list of important Anabaptist characteristics certainly lets us assume that he was exposed to and understood the *Confession of Faith*. This assumption is supported by his statement about his active participation in his local church community, which included being on the peace commission, serving in choir, as elder, and on the pastoral search commission.

In order to be congruent with the remarks about observation, we now need to investigate how this physician took his observation of the Mennonite Community and made it into a position finding map for his life.

[The] Development of my ethical principles has been significantly influenced by teachings regarding agape love and non-resistance [and] has been important in determining norms for behaviour. Teachings regarding servanthood. The experience of foot washing²⁶⁰ within the Anabaptist tradition has been instrumental in determining norms for interpersonal behaviour. Teachings regarding simple living have been significant in setting priorities for the way in which Lois and I choose to live. ... Teaching regarding non-conformity-*in the world but not of the world*-has been influential in my sometimes non-traditional choices within the profession.²⁶¹

The motivational forces in his life are listed now. These forces are identical with those we found in Articles 21-23 of the *Confession of Faith*: his norms of behaviour are agape-love and non-resistance, servanthood, simple life, and non-

²⁵⁸ Interview # 1, p. i, lines 31-33.

²⁵⁹ Interview # 1, p. ii, lines 60-71.

²⁶⁰ *Confession of Faith in a Mennonite Perspective*. Article 13, "Footwashing" was an integral part of Anabaptist/Mennonite church life in the past, and is still practised in many churches as a sign of mutual submission and service.

²⁶¹ Interview # 1, p. i, lines 45-56.

conformity. On one hand, he finds his ethical principles informed by his theological framework, but on the other hand, he also finds his theology challenged by external demands on these ethical principles.

At this point we take the third step observation asks of us, namely to ‘make an observation’, to say something about what has been observed before and has been formed into guiding principles for one’s journey.

Servanthood vis-a-vis the paternalism that was part of the professional acculturation during training. Managing patients with behavioural disorders or mental illness. Given the power of new drugs, do we control the behaviour to conform to normative behaviour? Some of the world’s great artists had bipolar disorder. Should individuals be controlled to such an extent as to compromise creativity? Contending with the imposition of market theory in physician-patient decision making, the US has resorted to imposing financial risks on decision-makers (physicians and patients) as a means for reducing costs of health care. This pits self-interest against the interest of the patient and creates conflict with traditional medical ethics and my personal ethics. In my personal position, this is the most difficult conundrum I face. I believe it will be a major ethics dilemma for the profession for the early part of the 21st century.

Managing patients at the end of life. Participating in the irrational prolongation of biological existence through technological interventions runs counter to personal beliefs about the sanctity of life.

Ethical dilemmas countered in the conflict between individual good and social good. The individual may run a course that utilises scarce resources in a way that is detrimental to the social good. “The tragedy of the commons.” There is a significant problem for those of us involved in public health.²⁶²

The current problems of health care in the USA are stated very clearly. This interviewee also asks how the theological convictions, which seem to have been a major force for his entering this profession, can inform his professional conundrums. By turning his argument around, he also asks how those ethical problems challenge his theological convictions. We do not know how he resolves this problem, neither is it the main focus of this dissertation. But this case shows us the centre in which the research question is located: what kind of relationship have theology and ethics? Can one do ethics without theology or theology without ethics?

In our search to understand observation, we have now come full circle. In order to complete the entire hermeneutical circle, however, next we need to investigate participation. A different interview has been selected to highlight the specific focus of participation.

²⁶² Interview # 1, p. ii-iii, lines 77-78, 81-91, 95-101.

2. Participation

Participation derives its meaning from the 16th century Latin *pars capere*, meaning to take part.²⁶³ It is described as ‘taking part’ and denotes a quality or action. Moreover, *pars* also indicates that before one can take part in an action, one needs ‘to be’ part of something or someone. This particular step is stressed very much in Anabaptist/Mennonite thought. As seen in the confession above, taking the voluntary step into the community of faith enables one not only to be part of this community and observe it, it enables one also to part-take, to participate in this community. Our second interviewee puts part-taking in the following words.

It is hard to separate the two [Anabaptist theology and ethics]...Our theological teachings were a heavy dose of Bible quotations from the pulpit. It was there, no doubt, we all took it as a part of our life to do things for other people. ...My parents came out of that conservative atmosphere where behaviour was extremely stressed, but belief was only having the right behaviour....They got into the Mennonite church at the height of the movement into this Mennonite fundamentalism. Stressed was dress, but also stress very much an experience of salvation, a saved type of thing....The reason I’m saying this [relating his conversion experience] and then going to Goshen College and starting to get some courses. I got a Bible major in addition to my science major, had great teachers, and I started to reflect on what is important in terms of Christianity.²⁶⁴

Participation is more than observation but not yet as much as embodiment or owning, even though embodiment and application are closely intertwined. In this case, the physician knew that ‘becoming part of the church’ needed to be worked out on his own personal terms, so he can own his own faith; taking on someone else’s rules (dress and behaviour) was not enough for him. In his case, college was the decisive time and place to reflect on past observations. In addition, college also gave him freedom to explore and participate on his own terms. And yet, we still find close connections to home and primary relationships.

The only thing against it [was that] when he knew I was serious about it [becoming a physician], I think he expressed once a concern about evolution being taught. And that was the only thing, other than that he was extremely supportive and went out of his way to see that I could afford to go medical school, even though he couldn’t personally help me. He had no finances himself. I was going to drop out of college, but he talked to my sister and asked her whether she could loan me money so I could go to college. It was really interesting I was even planning on going into Voluntary Service for a couple of years, which would have been quite approved, but when I told him

²⁶³ COD: “Participation”.

²⁶⁴ Interview # 6, p. i, line 13, p. ii line 62-64, p. ii line 82-87, p. iii line 109-113.

I really liked to go back to college to get into pre-med, that was when I made my decision at that point, he was very supportive.²⁶⁵

Participation in the hermeneutic circle happens in many ways, but in Mennonite understanding it is often encouraged in terms of practical service. A voluntary service term is welcomed and strongly supported by parents and church communities alike. "Voluntary service is intended to express agape love in its purity and in its simplicity in accordance with the synoptic idea," states J. Lawrence Burkholder in his chapter on Mennonite Social Services.²⁶⁶ He compares Mennonite Social Services under the auspices of the Church with secular social action programs. Voluntary Service projects grew out of the Mennonite Churches' emphasis on separating church and state, and provide a place of alternative service to the military.²⁶⁷

This physician's period of participation extended into his service work as a physician. He spend a total of 6 years in overseas medical services, in Central America and Africa respectively. In addition, he has 17 years experience as a general practitioner and surgeon in a rural setting where the general population was approximately 40% Amish. Today, he and his wife co-direct a retirement village, which presumably draws on his medical experience as well.

We can see here how participation extends into embodiment or ownership by including the main ingredients of simple life, non-conformity, peace and justice, and stewardship.

3. Embodiment

Embodiment or living out one's conviction occurs as a result of observation and participation. Implementation of faith is the process of putting something into motion; the meaning of this word is derived from the Latin *implere*, to employ. To employ the confession of faith is interpreted in this dissertation as describing the process of making the confession one's own and relating it to real life situations. In the case of the third physician, this means first and foremost trying to understand how his faith works in real life. Like the physicians of the previous examples, he grew up in a Mennonite community, participated in its programs, chose this faith and theological approach to be his own, and started to own and implement it in his college years. He describes his experience as one of activism, both politically and in the church.

²⁶⁵ Interview #6, p. i, line 36-45.

²⁶⁶ Burkholder, *Problem of Social Responsibility*. 179 ff.

²⁶⁷ <http://www.mennonitevs.org>

In college we had a lot of discussions about ethics, what should we be doing, should we be protesting [against the war in Vietnam], talking to government, how violent can we be, so, I was in the middle of that. You didn't have to be in the middle of that, you could be at the periphery and not think about it. So I think, doing what's right, living right has always been important.²⁶⁸

His activist mind-set did not stop after he entered medical school. It rather seems to be the driving force behind his wish to bring his personal and professional actions in line with his faith and theological reasoning.

I guess walking the walk. People who come to our church from other churches, they would say 'you Mennonite people really do take your faith seriously'. What that means is I think is following, discipleship I think that is the key difference. I don't say the other faiths have the right ethics, but often they don't follow, they talk in church and then they don't do it. I think we were taught to do it. That was brought home to me when my daughter married an orthodox Presbyterian. These orthodox Presbyterians, when you talk about service, right away their flags go up and they say 'uhm, one of them who want to earn his salvation', and you don't do that. In fact you don't do service because that might look like earning, it's just the way in this tradition, you don't talk about peace and justice and those things because it is like you want to earn your salvation. It has nothing to do with earning your salvation, it's just as a Christian you do this... With us, ethics is doing, because you believe this, you do this as well.²⁶⁹

In his understanding faith and actions belong together like two sides of the same coin. Over a span of 25 years he has participated in 7 years of voluntary service as a medical missionary with Eastern Mennonite Missions and Mennonite Board of Missions. He is still a resource member for one of these Mission Boards, and has very deep convictions about the need to bring a Mennonite theological perspective to biomedical ethics. This conviction has grown in him as he works as a physician in a rural setting, but is also a result of his medical involvement in the developing world.

Somebody's got to speak out for the poor and the oppressed. I think we get stuck talking about human sexuality, but forgetting the gap between our people here and our brothers and sisters in Africa. We know its awful but don't do nothing about it. ...Justice would be number one. Why do we spend millions of dollars to keep that 18 week foetus alive and in Africa there is no choice, that baby dies? And here it makes it to 4 month and then dies \$ 300'000 later? To me that's a justice issue. I don't think one person's life is worth the whole world, even though it says so in the Bible. When it comes to money, it just doesn't feel right to put all our resources in one person. Why do we save only one person and let millions die? The tropical diseases are the forgotten diseases of the forgotten people. Millions of people have

²⁶⁸ Interview # 8, page i, lines 45-49.

²⁶⁹ Interview # 8, p. ii, lines 71=83

malaria, for instance, but we don't put any money into it. Where is the justice in that?...

Just distribution. Individualism is totally foreign to scripture, in fact most of civilisation never thought in terms of individualism... We have resources, we have limited resources, and what are we going to do with it? I read the first chapter in this Rogers' book²⁷⁰, and thought why can't we have a Mennonite insurance? I went with SET to Haiti when I was a medical student. Africa and Haiti were terrible. Peace is important but other churches do that now too, they look at the Mennonites and see what happens there, but justice is still forgotten.²⁷¹

In the example of this physician's life we can see how the cycle of observation and participation has been closed by embodying his faith in praxis. In his reflections, he refers back to the Scriptures, and he also voices significant critique of Anabaptist/Mennonite theory and praxis in health care. Like the physicians in the previous examples, he stresses the relationship between faith and action, along with the need for one to be informed by the other in order to arrive at a congruent lifestyle of integrity. What will it mean for the Mennonite Medical Association, and for the Mennonite Church in general, to take such a critique seriously? If these practitioners point out the incongruence between theological theory and practical application, what will need adjustment? The theology or the practice? According to Gadamer's *Zirkelstruktur des Verstehens*, the community needs to come together and discuss these issues of discrepancy and discern together appropriate steps for the future.

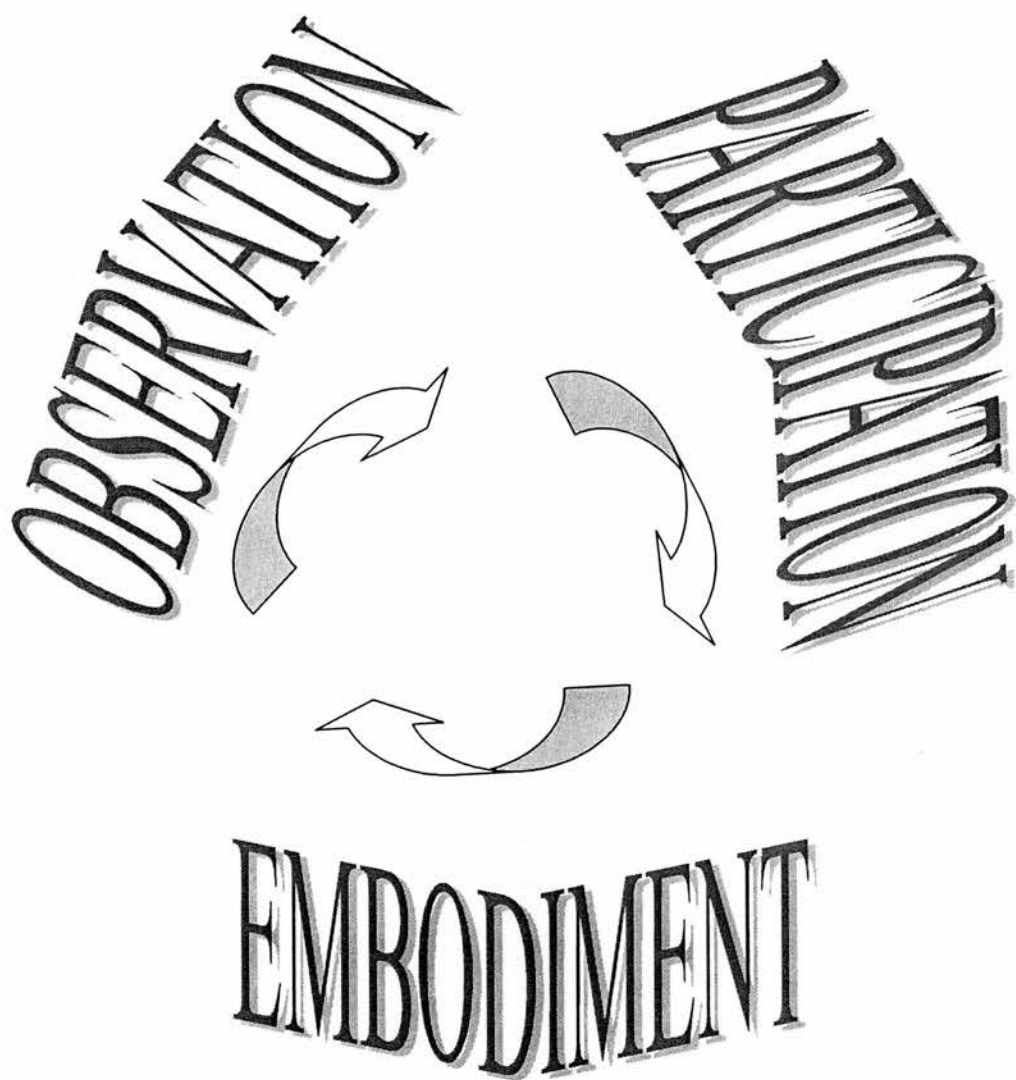
With these observations about the practical applications of the *Confession of Faith*, we are now ready to enter the theological discussion of servanthood, peace and non-violent justice, and community. This discussion will clarify the concepts and also aid in the setting of a framework for a Mennonite medical ethics.

²⁷⁰ Rogers, John, *Medical Ethics, Human Choices: A Christian Perspective* (Scottsdale, PA: Herald Press, 1988).

²⁷¹ Interview # 8, p. iv-v, lines 159-162, 163-171, 186-187, 188-197.

TABLE 3

**Circular Structure of the
Formation of Character and Identity**



II. THEOLOGICAL THEORY FOR AN ETHICAL PRACTICE

The empirical research on which this dissertation is based, seems to imply that ethical practice cannot be divided from, or separated out of, its theoretical basis. In our case, the theoretical basis is a particular approach to theology, namely Anabaptist/Mennonite theology. This observation is significant as it gives rise to several questions: one question is whether and to what extent the theological basis can and should be divided from ethical practice? Another question arising from this observation is whether different approaches to theology could potentially result in different ways of reasoning, and could a variety of ethical applications therefore be possible as well? What kind of difference, if any, would there be between Mennonite medical ethics and a Catholic approach to medical ethics? Moreover, if different theological approaches differed from each other in their ethical applications, would a philosophically-based ethics likewise be different in its final outcome? If all these questions could indeed be answered affirmatively, would it not follow from this that theological voices need to be heard in the market place of biomedical ethics?

Since this dissertation can only be concerned with the question of the contribution of Anabaptist/Mennonite medical ethics, leaving all the other questions aside for future research, we will then turn to the theological concepts of servanthood, peace and non-violent justice, and community.

A) Servanthood

Anabaptist/Mennonite scholarship has clarified issues surrounding servanthood from a variety of angles. Most notably, it is due to John Howard Yoder that Anabaptist/Mennonite theology has become the focal point of scholarly interest of late. His publication of *The Politics of Jesus*²⁷² stirred discussions concerning the place and relevance of Jesus Christ in contemporary theology and ethics. In a chapter called "The Disciple of Christ and the Way of Jesus", Yoder asserts discipleship is not only following after the teacher, discipleship also implies participation and imitation.²⁷³ For this discipleship to be authentic, Yoder claims, three crucial steps are necessary. First, we need to participate in the love of God by "sharing the divine nature which defines our Christian existence, by forgiving others as God forgave us, and by loving indiscriminately as God does".²⁷⁴ Secondly, we need to participate in the life of Christ by "defining our existence through Christ, by dying with Christ and

²⁷² John Howard Yoder, *The Politics of Jesus: Vicit Agnus Noster*,. (Grand Rapids, MI: Eerdmans, 1994²).

²⁷³ Yoder, J. H. *Politics of Jesus*, 112-113.

²⁷⁴ Yoder, J. H. *Politics of Jesus*. 115-116. (Col. 3:9; Luke 6: 32-36;)

sharing the resurrection life, by loving as Christ loved and serving others as Christ served".²⁷⁵ Finally, to conclude the cycle of discipleship, we also need to be ready and willing "to suffer with Christ, to share the divine condescension, share one's life freely, practise servanthood instead of dominion, accept innocent suffering, and suffer with Christ the hostility of the world as bearer of the kingdom cause".²⁷⁶ Only by understanding and participating in the example of the New Testament Christ and his teachings, can we understand the political and social impact of the gospel message, Yoder says.²⁷⁷ Yoder's strong Christo-centric focus is an extension and significant clarification of earlier Mennonite scholars. In the post World War II era, Harold S. Bender's *The Anabaptist Vision*²⁷⁸ and Guy F. Hershberger's *The Recovery of the Anabaptist Vision*²⁷⁹ were among the major works dealing with Anabaptist/Mennonite history and theological interpretations.

With political and pastoral brilliance, Bender rescued Anabaptism from the trash bin of history as he excommunicated many rebels [of the Muenster uprising] and redefined normative Anabaptism as an evangelical commitment to Christ through community, discipleship, and non-resistance. Through Bender's historical theology, Anabaptism even won the respect of the reserved suit-and-tie scholars of the American Society of Church History. Bender's reconfiguration of Anabaptism has been useful for the believers church, giving it a normative narrative and moving it from sect to oppositional and counterculture impulses: communal solidarity over the autonomy of soul, discipleship or ethics over mere orthodoxy, and peace over holy crusades and politically just wars.²⁸⁰

However brilliantly Harold Bender introduced Anabaptist/Mennonite theology from the sidelines of historical and theological scholarship in the last century, it was the book *War, Peace, and Nonresistance* by Guy Hershberger which brought the focus back on servant leadership in a community which practises peace, justice, and non-resistance.²⁸¹ With Bender and Hershberger as the basis, Yoder could then strategically develop a biblical understanding of servanthood which extends its relevance far into theo-ethical, ecumenical, and socio-political

²⁷⁵ Yoder, J. H. *Politics of Jesus*. 117-120. (1 John 2:6; Rom. 8:11; 1 John 3:11-16; John 13:1-17; Rom. 15:1-7)

²⁷⁶ Yoder, J. H. *Politics of Jesus*. 120-124. (2. Cor. 4:10; Phil. 2:3-14; 1 Peter 2:20-21; Math. 20: 25-28; Luke 14: 27-33;)

²⁷⁷ Yoder, J. H. *Politics of Jesus*. 127.

²⁷⁸ Bender, Harold. S. *The Anabaptist Vision*.

²⁷⁹ Hershberger, *The Recovery of the Anabaptist Vision*

²⁸⁰ Holland, Scott. "When Bloch pointed to the Cages outside the Cathedral", in *Anabaptists and Postmodernity*, by Susan Biesecker-Mast and Gerald Biesecker-Mast (eds). Telford, PA; Pandora Press, 2000. 148.

²⁸¹ Hershberger, Guy, F. *War, Peace, and Nonresistance*. (Scottsdale, PA: Herald Press, 1944).

applications. For the cause of this dissertation we can only focus on the theo-ethical application of Yoder's thoughts on servanthood.

The *theo-ethical* relevance of servanthood in Yoder's writing needs to be understood in terms of interpretation and embodiment.

"Servanthood", says Yoder in *For the Nations*, "is not a position of non-power or weakness. It is an alternative mode of power. It is also a way to make things happen, also a way to be present. When we turn from coercion to persuasion, from self-righteousness to service, this is not a retreat but an end run."²⁸²

Yoder particularly emphasises the need to interpret Jesus' work and teaching not through the lenses of accepted traditions of Christendom. This tradition credits Jesus' life and ministry with a weak example to follow, hence his Christological and soteriological imperative has to be emphasised so much more to counterbalance his weakness in life.²⁸³ Servanthood includes for Yoder the following characteristics of the service of Jesus, the Christ: the call to, a religiously, ethnically, and economically mixed voluntary community, and a voluntary community which was offered a new way of life - forgiveness instead of hatred, suffering instead of violence, sharing instead of taking, serving instead of leading.²⁸⁴ This voluntary community is not an inevitable result for those who do not have any other options left, says Yoder. On the contrary, it is a conscious choice after all other options have been considered and failed.²⁸⁵ In *The Original Revolution*, but also in *For the Nations*, Yoder describes in detail the choices Jesus had considered before he established the new community. Jesus could have accepted the situation as it really was, or he could have become a revolutionary with the Zealots. If neither of these were viable options, there was always the desert into which Jesus could have retreated and been sectarian. The last option of non-involvement would have been to stay within society but to be separately uninvolved.²⁸⁶ However, all these options were non-options for the incarnate God, therefore "he created a distinct community with its own set of values and its coherent way of incarnating them,"²⁸⁷ and offered the above-mentioned characteristics by which to live.²⁸⁸

²⁸² Yoder, John, Howard. *For the Nations: Essays Public and Evangelical*. Grand Rapids, MI: Eerdmans, 1997. 191.

²⁸³ Cf. Alain Epp Weaver. "Missionary Christology: John Howard Yoder and the Creeds", MQR 74:3423-439. JI. 2000.

²⁸⁴ Yoder, J. H. *For the Nations*. 175-176.

²⁸⁵ Yoder, John Howard. *The Original Revolution*. Scottdale, PA: Herald Press, 1972.

²⁸⁶ Yoder, J. H. *For the Nations*. 169-174.

²⁸⁷ Yoder, J. H. *For the Nations*. 175.

²⁸⁸ Cf. Donald B. Kraybill, *The Upside-Down Kingdom*, (Scottdale, PA: Herald Press, 1990²).

Within the worldwide Mennonite community, Yoder's theoretical interpretations have been widely shared, but they have also been received favourably by scholars outside the Mennonite world.²⁸⁹ However, says J. Lawrence Burkholder, a fellow Mennonite with Yoder, we live in a world of drastic discrepancies between the "absolute love ethic of Jesus" in the Sermon on the Mount and the "structures of modern life".²⁹⁰ Burkholder does not entirely disagree with the theoretical expositions; however, he challenges the applicability of the theoretical ideal. He asks questions in light of his experiences as a relief agency volunteer in China, but also as a seasoned professor of theology and ethics at Harvard, a student of Reinhold Niebuhr, and as an activist who was jailed for marching with Martin Luther King Jr. in Boston. Burkholder's keen observations and interpretations of social processes and theological truths is continuously challenging the reader with the "tension between the 'idealistic ought' and the 'tragic and realistic is'".²⁹¹

It is my experience to observe that most Mennonite entrepreneurs, physicians, business experts, and administrators know very well that there is a conflict between the ideals of discipleship and the reality of their situations.²⁹²

It seems to be one of Burkholder's strengths to go on wrestling with questions of ambiguity, with issues of compromise, and with the quest for social responsibility in a denomination which has developed out of a largely separatist character. Burkholder's questions are similar to those asked by the interview subjects in the empirical research in Chapter II. These physicians stand in exactly the tension with which Burkholder charges the Mennonite churches today. If servanthood, caring, compassion, stewardship, and service are the attributes with which the physicians practise their craft, how do they apply the ideal of the gospel message to their reality as physicians in the USA? Before we can answer this question satisfactorily, we need to investigate how the emphasis on servanthood is related to peace and non-violent justice and to community. Once the inter-relation of these three principles are understood, we are ready to engage in the discussion with contemporary biomedical ethics and in the construction of a Mennonite medical ethics.

²⁸⁹ Notably among them James William McClendon Jr. (*Systematic Theology*, vol. 1; *Doctrine*, Vol. 2; and *Witness* Vol. 3. Nashville: Abingdon, 1986, 1994, 2000 respectively) and Stanley Hauerwas. (*Theology Without Foundations: Religious Practice and the Future of Theological Truth* (Nashville: Abingdon Press, 1994. "Confessions of a Mennonite Camp Follower." *MQR* 74: 511-522, Oct. 2000.

²⁹⁰ Burkholder, J. Lawrence, *The Problem of Social Responsibility*. 222-224.

²⁹¹ Sawatzky, Rodney J. and Scott Holland. (eds.) *The Limits of Perfection: A Conversation with J. Lawrence Burkholder*. (Kitchener, ON: Pandora Press, 1993²). iv.

²⁹² Sawatzky, *Limits of Perfection*. "Concluding Postscript". 146.

B) Peace and non-violent Justice

The ancient understanding of peace, εἰρηνῆ, has been a synonym for the antithesis of war (Homer), for peaceful conduct in community and towards others (in Plato and Epictetus), and since the Stoics, peace has been understood also in terms of spiritual peace.²⁹³ In the LXX, εἰρηνῆ is synonymous with the Hebrew שְׁלָמִים, shalom, which is mostly used for greetings including wishes of overall well-being, the absence of war, rest, safety, freedom from care and trustfulness (Isa. 57:18; Ps. 38:3). In the New Testament, Christ is understood as the one who brought God's peace for humanity's reconciliation with God. Reconciliation is only possible through humanity's redemption by God, a redemption which is made explicit in the new community of the redeemed and which inaugurates the new eschaton (Rom. 5:1; Col. 1:20; Lk. 2:1; 2 Cor. 5:17; Gal. 6:15). The ministry of Jesus was one of healing and wholeness, a ministry of bringing newness in relationship between people and between people and God, and it was also a ministry that connected peace with reconciliation and justice.

The disciple, εἰρηνοποιός (peacemaker), who is perfect in the sense of bringing the wholeness which comes from God alone and which is intimately bound up with the experience of God's presence, is one who brings peace in the fullest sense of the term שְׁלָמִים, shalom. As such, the peacemaker is a son of God fulfilling the destiny and title of Israel (Deut. 14:1; Hos. 1:10; Ps. Sol. 17:30; Wis. 2:13, 18).²⁹⁴ Becoming a disciple of Christ, a peacemaker, includes servanthood, living and imitating what Christ did. If we understand Yoder right, servanthood is not ruling with the powers of the establishment, but subverting the powers with service, compassion, care, and enemy love. If coercion, oppression, and violence are the motivational forces of the established order which Jesus criticised, then what are the motivational forces by which the disciples of Christ live? For Yoder, as for his early Anabaptist forefathers, becoming a disciple of Christ involves a clear denouncement of violence and injustice. But what does it mean to denounce violence in a world of ever increasing violence? Is there not always the possibility of inadvertently doing an injustice, even in our best attempts? In order to understand how peace and non-violent justice work, we need to investigate several underlying concepts which have significantly shaped Anabaptist/Mennonite scholarly interpretation in the area of peace and non-violence.

²⁹³ The following exegetical expositions are taken from the New International Dictionary of New Testament Theology (DNTT) CD-ROM. "Peace". Paternoster Publishing.

²⁹⁴ DNTT: "Peace".

Atonement and eschatology are integral concepts to understanding peace and non-violence in Anabaptist theology and ethics.

Atonement. The Christus Victor motive is central to understanding Anabaptist/Mennonite peace and justice. As opposed to the Anselmian satisfaction theory of atonement, where Christ died as a substitute for human sin, or the Abelardian moral influence theory, in which Christ died as an example of God's love to humanity, the Christus Victor motive is a model of empowerment rather than of disempowerment.²⁹⁵ Satisfaction theory and moral influence theory, says Weaver, are intrinsically individualistic and lack the perspective of the church as an alternative social structure.²⁹⁶ Besides the church's being "co-opted by the empire" when she accepted the sword and fought in the name of Christ, we also find the "accommodation of sin when the post-Constantinian church adopted a minimal ethic for Christian".²⁹⁷ According to Weaver, the problem of accommodated sin and minimal ethics was supported by Anselm's interpretation of the satisfaction theory.

"In contrast, the Christus Victor motive, by assuming a church that posed an alternative to the social order, implies the creation of a saved social structure as an integral part of salvation. This structure is the church as the earthly manifestation of and testimony to the reign of God...By understanding the salvation within the framework of the victorious Christ, who makes present the reign of God, salvation is seen inherently to include saved relationships and structures as well as individuals...The more clear we are about the specific historical reality of the confrontation between church and social order,, the more clear it is that salvation has a social component and expression, belonging to the people of God. Hence the work of Christ must be dealt with in such a way as to understand that social component is intrinsically to the work of Christ."²⁹⁸

If Weaver's interpretation of Gustav Aulen's *Christus Victor*²⁹⁹ motive is correct, what impact might that have on the motivational forces of peace and non-violent justice? If the church is indeed a new social order of the called-out believers, how can this church be manifest in the polis?³⁰⁰ Will it be possible for the church to

²⁹⁵ Cf. J. Denny Weaver, *Keeping Salvation Ethical: Mennonite and Amish Atonement Theology in the late Nineteenth Century*, Cornelius Dyck, (et. al.) Vol. 35, *Studies in Anabaptist Mennonite History* (Scottsdale, PA: Herald Press, 1997).

²⁹⁶ Weaver, J. Denny, *Keeping Salvation Ethical*. 48.

²⁹⁷ Weaver, J. Denny, *Keeping Salvation Ethical*. 46-47.

²⁹⁸ Weaver, J. Denny, *Keeping Salvation Ethical*. 48-49.

²⁹⁹ Aulen, Gustav. *Christus Victor: A Historical Study of the Three Main Types of the Idea of Atonement*. (New York: Macmillan, 1969.)

³⁰⁰ Cf. Arne Rasmussen. *The Church as Polis*. (Notre Dame, IN: University of Notre Dame Press, 1995). Stanley Hauerwas, *In Good Company: The Church as Polis*. (Notre Dame, IN: University of Notre Dame Press, 1995).

be the church and live by different standards from the world?³⁰¹ In order to answer these questions, we need to understand the eschatological significance of following and imitating Christ.

The eschatological impact of Jesus' resurrection empowers individuals and the community to live according to the standards of Christ: non-violence and justice. With the death and resurrection of Christ the new kingdom order has already begun and is to be displayed by the embodiment of the community of disciples, but will not be fully consummated until the second coming of Christ. Donald Kraybill's *Upside-Down Kingdom* is a marvellous description of the kind of kingdom community the church is (or can be). He points out four classic misinterpretations of the Jesus Christ of the gospel account, namely, a) Jesus was too culturally bound which negates any but theological application for the 21st century; b) Jesus himself was unsure about the timing of the kingdom; c) there is only spiritual, not social meaning in the gospel account of Jesus' life; and d), the kingdom Jesus talked about has impact only on our personal character.³⁰²

Anabaptist/Mennonite theology does not completely agree with this interpretation of the gospel account of Jesus. Anabaptist/Mennonite scholars stress repeatedly the eschatological impact of Jesus' resurrection power on both the individual and the community in the present time.³⁰³ Moreover, Norman Kraus' treatment of *agape love* as the motivation and rule for kingdom living³⁰⁴ supplies us with the connective element between the individual and communal application of this eschatological impact. In addition, now we understand better the interrelation of the individual's transformation through the power of Christ as symbolised in the confessions, and the community's dynamic application in the world around them.³⁰⁵ In *The Christian Case for Virtue Ethics*, Joseph Kotva explains Anabaptist/Mennonite understanding of eschatology based on the life, death, and resurrection of Christ, as follows:

this eschatological development is the context of Paul's movement between indicative and imperative. The indicative reflects what God has done, is

³⁰¹ Cf. Diane. M. Yeager. "The Social Self and the Pilgrim Church", in *Authentic Transformation: A New Vision of Christ and Culture*, by Glen Stassen, (et. al.) (Nashville, TN: Abingdon Press, 1996.) 91-162.

³⁰² Kraybill. 24-34.

³⁰³ Cf. Walter Wink. *Engaging the Powers*. Philadelphia: Fortress Press, 1992.

³⁰⁴ Kraus, *Jesus Christ our Lord*, Chapter 7, 133-146.

³⁰⁵ For an excellent treatment of this connection see John Howard Yoder's *The Priestly Kingdom: Social Ethics as Gospel*. Cf. Chapter 4: "The Kingdom as Social Ethics". 80-101. (Notre Dame, IN: University of Notre Dame Press, 1984.)

doing, and will complete. The imperative reflects our wait for the final consummation. While living in this time, we strive to have our lives reflect both what God has done and will do. ...The need for Paul's moral encouragement, advice, and admonition thus derives from the discrepancy between who-we-are-called-to-be-as-Christians and who-we-actually-are (as shown in our actions and attitudes). Paul's advice, encouragement, and chastening helps believers move from the latter to the former.³⁰⁶

If the church, as the disciples and imitators of Christ, live in this new eschaton already, by what standards are they to live? Should they try to transform the rules and regulations of the old eschaton?³⁰⁷ Should they try to keep the old standards and incorporate the new ones as well? Not so, says James McClendon. "Jesus the preacher of peace took the way of the cross as a deliberate alternative to the ways of violence."³⁰⁸ Such is the way of Christ we are to imitate as the body of believers in the world.

The witness of *Peace* and *non-violent Justice* are the most essential teachings in Anabaptist/Mennonite ethics. The biblical witness of Jesus informs us that without Christ's death and resurrection peace is impossible. In Anabaptist/Mennonite theology, peace happens on three inextricably linked and interrelated levels. First, there has to be personal peace of the individual with God, which is a prerequisite for the second level, peace within the church community. Without the acceptance of Christ's death and resurrection it is impossible to attain personal peace, consequently, peaceful living within the church community will not be a possibility either. "The central point is that believers are to be disciples of the Prince of Peace, disciples who are devoted to the mission and the means of Jesus and not the values and ways of the world."³⁰⁹ Barry Callen's summary points to the third level in Anabaptist/Mennonite theology, namely structural peace. As a community of peace we are called to challenge, and if possible, reform structures of injustice and oppression. This call is again rooted in the biblical mandate to care for those who do not have the power to care for themselves (Matt. 25). The question to answer is then, what are the means by which peace is to be obtained? Central to Anabaptist/Mennonite theology, peace can only be had by non-violent and peaceful means.

As important as *who* Jesus identified with is *how* he identified with them. Those who would follow Jesus must adopt his way of being on the side of the

³⁰⁶ Kotva, *Christian Case for Virtue Ethics*. 127-128.

³⁰⁷ Niebuhr, H. Richard *Christ and Culture*. (New York, Harper, 1951).

³⁰⁸ McClendon, James, William, Jr. *Systematic Theology: Witness*. 79.

³⁰⁹ Callen, *Radical Christianity*. 150.

victims. Jesus rejected violence as a way to help the powerless and alleviate their suffering... From the Anabaptist-Mennonite perspective, perhaps the single most important contribution to the modern world is the emphasis on peace as integral to the Christian message. Peace is not a nice ideal to be abandoned in the name of a higher good like national pride or the survival of capitalism or the institution of democracy. To people who follow Jesus, peace is a way of life which cannot be abandoned without abandoning him as well... Non-violence and non-resistance could be considered a more specific application of the idea of Jesus as the norm of Christian behaviour.³¹⁰

J. Denny Weaver is one among many Anabaptist scholars³¹¹ who emphasises peace and non-violence as inherent to the teachings of Jesus Christ. If our assumption is correct that the death and resurrection of Christ has inaugurated a new kingdom order and has ordained the believing community as the witness of this new eschaton, then the standard, and the mission by which this community reflects the way of its founder, Jesus Christ has to be congruent with Christ's way of peace and rejection of coercion. In other words, Christ's life has shown that the end – the new kingdom order, and the means – peace and non-violence have to be congruent in order to have an impact. The church is called to practise the same congruency of end and means in her daily embodiment if she is to be called a disciple of Christ

If Christ has really inaugurated a new eschaton with his death and resurrection, and if the way of life in this new eschaton is one of peace and non-violence, as many Anabaptist/Mennonite scholars point out, what role does the community of believers have in this new eschaton? Is the community of believers just another social group that meets around the needs of the individual members of the group, or has the community of believers a bigger, a social mandate?

C) Community

The strong emphasis on community is a consequence of the Anabaptist/Mennonite theological interpretation described above. Christ has called a new community into existence, a community of those who do his will in this world. In its ideal application, this community supersedes family ties, ethnicity, even nationality (Mk. 3: 31-35; 10:28; Lk. 14: 26-27). Being called into the community is being called to participate in the new eschaton that was initiated by Christ. Entering into the community of believers asks for obedience: obedience to God, to the word, and obedience to the ordinances set by Jesus Christ. Baptism usually signifies the

³¹⁰ Weaver, J. Denny, *Becoming Anabaptist*. 134-136.

³¹¹ Cf. Thomas, N. Finger. *Christian Theology: An Eschatological Approach*. (Scottsdale, PA: Herald Press, Vol. 1 1985, Vol. 2: 1989.) C. Norman Kraus. *Jesus Christ Our Lord: Christology from a Disciple's Perspective*. (Scottsdale, PA: Herald Press, 1990²), and *God our Saviour: Theology in a Christological Mode*, (Scottsdale, PA: Herald Press, 1991).

entrance into the community, and the Lord's Supper continuously reminds individuals and the entire community of their commitment to each other and to Christ. Through the faithful application of scriptures, the hermeneutic community emerges with theological interpretations that demand congruency between personal belief and scriptures. As seen above, the Anabaptist/Mennonite interpretation of community has adopted the concept of 'hermeneutic community'.

The hermeneutic community is what the believers church calls "communities of interpretation."³¹² The interpretative community is pivotal to the concept of Anabaptist/Mennonite theology on the basis of the priesthood of all believers. The marks of the hermeneutic community are

an emphasis on salvation received and lived out in the context of the new people of God, and a strong emphasis on lifestyle and discipleship. Crucial understanding of the sacred text is mediated by the Spirit as the Bible is opened in the fellowship and obedient life of the church. It is not that the church is lord of Scripture,...but the church is the vital context that is a shaping force, even while it is in the process of being shaped and disciplined by the Spirit.³¹³

Donald Kraybill calls this kind of hermeneutic community an "upside-down community with a different set of values and a different vision".³¹⁴ The church does not dominate Scripture, but Scripture continually challenges the practice of the community. Such practice brings Anabaptist/Mennonite hermeneutic into close proximity with the hermenutical circle of Liberation Theology. Anabaptists often seem to use church, community of believers, or hermeneutic community as synonymous terms. Such practice of interchanging terms might not help to define the exact use of the term community; however, the important point is that the practice is not 'every believer for him/herself', but it is the formation and practice, and within a community that matters greatly for Anabaptist/Mennonite. The practice of Anabaptist/Mennonite community has been formed in two crucial ways. There is first, the theological interpretation and ethical practice that has been discussed above. But the community ethos has also developed through a particular interpretation of social and cultural exclusion, due to the severe persecution in the 16th century and

³¹² Callen, *Radical Christianity*, 107. The term 'believers church' was coined by Max Weber and introduced in the US by Donald Durnbaugh's *The Believers Church* (New York: Macmillan, 1968).

³¹³ Callen, *Radical Christianity*, 108, 122.

³¹⁴ Kraybill, Donald, B. *The Upside-Down Kingdom*. 269. Cf. Leland Harder, *Doors to Lock and Doors to Open: The Discerning People of God*. (Scottsdale, PA: Herald Press, 1993). This discernment process is situated in a study called the Church Member Profile, where Harder and associates have studied five Anabaptist denominations in order to research what kind of churches are attracting what kind of persons and how that attraction materialises in day-to-day life of the church community.

onwards. The discussion about the social milieu in which Anabaptist/Mennonite ethos has developed is not the focus of this dissertation and has been discussed elsewhere.³¹⁵ The question for us in connection to the goal of this dissertation is whether the theological interpretation of the church (ecclesiology) in relation to Christ (Christology), has consequences for the ethical practice of the physicians in our study. If we can establish a causal connection between the theological interpretation and the ethical practice, then we might also be able to establish whether, and to what extent, such ethical practise might have an impact on the social surrounding in which the community (and the individual in community) finds themselves.

At the beginning of this chapter we have already discussed at length how hermeneutic community is defined in Anabaptist/Mennonite theology. We can therefore state that Anabaptist theology and ethics is first of all rooted and anchored in the scriptures, taking the life and example of Jesus Christ in particular as the measure for theological interpretation. Biblical exegesis, which is done in the gathered community of believers, is followed by theological interpretation which consequently flows into ethical conduct. In the article "History, Theory, and Anabaptism", Stanley Hauerwas has concluded that

it was crucial for me that Yoder teaches us to see that discipleship is internal to Christological display. Moreover, when you see that connection you also realise that you cannot avoid social location-which would be another way to say church-for thinking about what kind of community is capable of sustaining the continual concrete display of the life of Jesus.³¹⁶

In the discussion between Hauerwas and Chris K. Huebner we see the first glimpses of a rather different ethical approach to the one we would ordinarily find in contemporary ethical deliberations. The former situates ethics in the context of, and relationship to, the theology of the believing community, whereas the latter seems to put much emphasis on the individual's right and autonomy. For Anabaptists, community is not an entity that is restrictive or detrimental to the individual's personal development. Community is the place where the individual can be a participant observer until he/she has decided to become an active partner in this

³¹⁵ Cf. *The Mennonite Experience in America Series*, there is particular Richard K. MacMaster, *Land, Piety, Peoplehood: The Establishment of Mennonite Communities in America 1683-1790*. Vol. I. (Scottsdale, PA: Herald Press, 1985). Toews, Paul, *Mennonites in American Society, 1930-1970: Modernity and the Persistence of Religious Community*. Vol. 4. (Scottsdale, PA: Herald Press, 1996).

³¹⁶ Stanley Hauerwas in "History, Theory, and Anabaptism: A Conversation on Theology after John Howard Yoder," in: *The Wisdom of the Cross: Essays in Honour of John Howard Yoder*, by Hauerwas, et. al. (Grand Rapids, MI: Eerdmans, 1999). 394.

community. It is the practise of the sacraments on the basis of the *Confession of Faith* that shapes the individual's and community's character in an environment of participant observation, as we saw in first part of this Chapter. When the community of believers than actually embodies their practise of the sacraments through their vocational choices, their theological interpretation will indeed be a social impact.

Conclusion to the Chapter

In this chapter we have set out to answer the question of what kind of contribution Anabaptist/Mennonite theology could make to issues of current biomedical ethics. Anabaptist theology and ethics has been chosen as a theological example because of its emphasis on the hermeneutical community. This hermeneutical community follows a circular, inter-dependent pattern of observation, participation, and embodiment. This pattern seems to have its roots in early Anabaptist history and theology, and has become instrumental in the formation of character and virtue. Several research examples have helped us to understand the significant influence of the hermeneutic community on their development as Mennonite physicians. Through their observing the hermeneutic community, participating in this community, and finally embodying such a theology of community in their medical careers, we have been introduced to three significant concepts. Firstly, servanthood has been identified as a way of being present in the physician-patient relationship. Secondly, peace and non-violent justice has become the motivational force for the physicians in their medical careers, and thirdly, community resources have been identified as a necessary support system for both physician and patient.

In the second part of this chapter we have surveyed Anabaptist/Mennonite literature for the theological grounding of the three emerging concepts. We found servanthood, peace and non-violent justice, and community based on a theological interpretation of Christology, ecclesiology and eschatology. Again, these three theological terms are inter-dependent, and interpretation of one concept has significant influences on the other two concepts. As with the connection between observation, participation, and embodiment, the theological concepts are connected with, and dependent on each other. In Anabaptist/Mennonite theology the interpretation of church (ecclesiology) depends on the interpretation of the meaning of Jesus (Christology). That Christological interpretation informs the understanding

of Mennonite eschatology-the Kingdom of God already implemented but not yet fulfilled-which in turn informs Anabaptist/Mennonite ecclesiology.

What would be the conceptual framework for a viable ethics based on servanthood, peace and non-violent justice, and community which should be applied in contemporary biomedical ethics? Can such a framework be applied to the pressing questions of current biomedical ethics? How will questions concerning health care be informed by such an ethical framework? Is it indeed possible to apply an ethic of servanthood, peace and non-violent justice, and community to health care in the 21st century? Before we can answer these questions in Chapter V, we will be introduced next to the intricate thinking of John Howard Yoder. With his scholarly work in the area of peace studies and social ethics, he has paved the way for the application of Anabaptist/Mennonite theology and ethics in questions of biomedical ethics.

CHAPTER V

DISCUSSING THE EMERGING THEMES WITH JOHN HOWARD YODER

Introduction to the Chapter

In Chapter IV we have been introduced to Anabaptist/Mennonite theology and the inclusion of three distinctly Anabaptist/Mennonite emphases, servanthood, peace and non-violent justice, and community. It was argued that these three Anabaptist emphases should be included in biomedical ethics, because we find in this theological approach features that appear to bear close resemblance to features of virtue theory. These features are observation, participation, and embodiment, and they resemble Aristotle's emphasis on the apprentice/master relationship. The theological basis of this dissertation has been introduced by the empirical research among Mennonite physicians in Chapter II and Chapter III. The analysis of the physician's biographies demonstrated that both role models and distinctive Anabaptist theological teachings were instrumental in their choice of career.

The burden in Chapter V is now to find one main theological discussion partner who will provide a theoretical construct that unifies the theological findings and the empirical study. The conversation partner for this chapter will be the Mennonite theologian John Howard Yoder. In the first part of Chapter V under the headline "Emerging themes with theological-ethical content," we are providing insights into the three principles of Anabaptist/Mennonite ethics from the empirical study, namely servanthood, peace and non-violent justice, and community through the thoughts of John Howard Yoder. Yoder could be characterised as one of the foremost thinkers in Anabaptist/Mennonite theology of the last part of the 20th century. His ideas will be compared with excerpts from the research interviews and the physicians' discussion on servanthood as a model for physician conduct. From the analysis in Chapter IV, servanthood appears to be one of the vital parts of Anabaptist/Mennonite theology, and it is now our task to identify similar ideas in the authorship of Yoder. Secondly, we will discuss peace and non-violent justice as the *modus operandi* for servanthood, and thirdly, we will concentrate on community as the forum for sustenance and sending in the thoughts of Yoder.

In the second part of this chapter we will discuss themes that have emerged from the interviews and have been summarised under the heading "Emerging themes with philosophical-ethical content". The discussion between John Howard Yoder's

thoughts and the emerging themes from the interviews will be vitally important for the completion of the four steps of narrative analysis as indicated in Chapter III.³¹⁷

I. EMERGING THEMES WITH THEOLOGICAL-ETHICAL CONTENT

A) Servanthood as a Model for Physician Conduct

Servanthood has won increasing attention as a theme in biomedical ethics over the last several years.³¹⁸ Servanthood is not an entirely new thought in biomedical ethics, it has long been an important concept in medical ethics, as the scholarship of William May states.³¹⁹ He is among the very few theologians who consistently pointed to the responsibility of the physician in the art of healing in *The Physician's Covenant*. Even though these concepts of covenant and presence³²⁰ are well balanced and inclusive in their approaches, they do not take into account the Radical Reformation view of servanthood.

As we have seen in Chapter IV, the Anabaptist/Mennonite understanding of servanthood is closely intertwined with embodiment of theology and ethics. Anabaptist-Mennonites do not believe in the viability of a theoretical theology in and of itself; their theology needs to be embodied or contextualised in everyday existence. The process of observing, participating, and embodying³²¹ helps Mennonite physicians to understand their careers as service to God. Consequently, servanthood becomes an embodied way of life rather than a theoretical ideal. If the physicians of this study are correct in taking up the challenge to practise servanthood in their careers, we first need to understand the aetiology of servanthood. This aetiological investigation will include the four individual components of service, stewardship, caring, and compassion, which were strongly stressed by the physicians. Next, we need to trace servanthood in the thought of John Howard Yoder and compare it again with the ideas of the physicians.

³¹⁷ Riesman Kohler, *Narrative Analysis*. 65-67. The four steps for the completion of narrative analysis are: persuasiveness and plausibility, correspondence, coherence, pragmatic use.

³¹⁸ Kilner, John, F., Nigel M. De S. Cameron, and David L. Schiedermayer. *Bioethics and the Future of Medicine: A Christian Appraisal* (Carlisle: Paternoster Press, 1995). Cf. John Kilner, (et al). *The Changing Face of Health Care: A Christian Appraisal of Managed Care, Resource Allocation, and Patient-Caregiver Responsibility*, The Centre for Bioethics and Human Dignity, *Horizon in Bioethics Series* (Grand Rapids/Cambridge: William Eerdmans Publishing Company, 1998).

³¹⁹ Cf. William F. May, *The Physicians Covenant: Images of the Healer in Medical Ethics* (Philadelphia: Westminster Press, 1983). *Testing the Medical Covenant* (Grand Rapids: Eerdmans Publishing Company, 1996).

³²⁰ May, William, F. *The Patient's Ordeal*. Medical Ethics Series, ed. David H. Smith and Robert M. Veatch. (Bloomington: Indiana University Press, 1991).

³²¹ Cf. Chapter IV.

1. Aetiology of the term Servanthood

Servanthood as a term is a compositional phrase, composed of the noun *servant* and the suffix *hood*. The suffix denotes a condition, quality, collection, or a group. Its origin is old English and describes a group of people. Servant, on the other hand, describes an individual, and is often associated with someone who performs domestic duties. For the purpose of this dissertation it is necessary to distinguish between a civil servant, who is a person who performs duties for a particular government, and a servant of God. The latter term often describes a person who performs religious duties or works for an ecclesiastical organisation.

In the context of this dissertation, servanthood is used in a holistic way. The interpretation provided by the interviewed physicians is that servanthood is used for caring, compassionate, and serving stewards. The physicians see themselves as stewards of God's creation, stewards of their talents in their careers, and stewards of their time and money. By using their careers in the service to God, they not only fulfil a mandate of God in creation, they also understand their careers as service to society at large, and all the members of the civic society. In order to understand the cause of this line of reasoning, we need to make a brief excursion into the biblical origins of the meaning and mandate of a servant.

2. Biblical origins of *Servant*

The Old Testament origins of the term 'servant' are closely related to the term stewardship, a term that was often mentioned in the interviews. The servant of the Lord is called out or set aside for a particular kind of work (1 Sam. 3:9). The first man, אָדָם (adam), was set in the garden "to till and to keep it," to work in the garden as a steward of the Creator God (Gen. 1:28; 2:15). Being created by God and called to serve implies the responsibility of stewardship for the first human being. David was the "anointed of the Lord," to serve as King of Israel (1 Sam. 16:13); his son Solomon prayed "give your servant wisdom to govern your people and to discern between right and wrong" (1 Kings 3:9). Servants were set aside to be stewards over God's creation and God's people, they were called and anointed to lead a life of service and to care for the things that had been entrusted to them.

In the New Testament, the inaugural scripture which Jesus read in the temple identified him as a direct successor of the Old Testament prophetic tradition (Luke 4: 18-19). He identified the objective of his ministry - to bring good news, to proclaim release and recovery; he identified the target group of his service: the poor, the captives, the blind, and the oppressed. In the Sermon on the Mount, Jesus goes into

more detail about how the objective of his ministry should be carried out (Math. 5-7). In the succession of Old Testament thought, Jesus also embodied stewardship as a way of life.

Paul identified himself in most of his letters as “servant of the Lord” (Rom.1:1). He repeatedly stressed the need for “servants of Christ and stewards of God...to be found trustworthy,” as 1 Corinthians 4:1-2 shows for example. In this New Testament context, Paul used the term *οικονομος*, to describe the task of the apostles of administering God’s household. The *δουλος*, servant, needs to fulfil various requirements of faithfulness, without which the *οικονομος*, the household of God, cannot be properly attended to (Lk. 12:42; Math. 25:12ff; 1 Peter 4:10).

The physicians in this study have stressed ideas similar to living and practising like Christ, who lived like a servant. This servant attitude includes wise stewardship of their talents, of their time and money, and the way in which they practise their professions. Compassion appears to be a vital component of the care they deliver through their work. It seems impossible for them to separate stewardship from care, compassion, and service. The question that the physicians have asked repeatedly is how can one be called a faithful and efficient steward if the medical service provided by the stewards is divorced from care and compassion?

3. Servanthood in the Thought of Yoder³²²

It is impossible to understand John Howard Yoder’s concept of servanthood without knowing his biography.³²³ His numerous publications also need to be read through the lens of his personal experiences as an Anabaptist/Mennonite Christian. He grew up in an Amish Mennonite Church which was part of the Ohio Mennonite Conference.³²⁴ Growing up Amish-Mennonite does not explain itself how Yoder would embody servanthood in his life. However, how he exemplified servanthood in his life and career displayed his deep love for the Mennonite Church, the larger Anabaptist movement, and the world-wide church of Christ.³²⁵ According to Mark Thiessen Nation, Yoder identified himself and his work historically and theologically

³²² For a fitting summary of Yoder’s life see the obituary “Remembering John Howard Yoder December 29, 1927-December 30, 1997” by Stanley Hauerwas at <http://www.firstthings.com/ftissues/ft9804/hauerwas.html>.

³²³ Thiessen Nation, Mark, “John H. Yoder, Ecumenical Neo-Anabaptist: A Biographical Sketch,” in: *The Wisdom of the Cross* by Stanley Hauerwas (et. al.) (Grand Rapids, MI: Eerdmans, 1999), 1-23.

³²⁴ Thiessen Nation, “John H. Yoder.” 6.

³²⁵ At this point it is necessary to draw attention to a vital, but often overlooked fact in Yoder’s writing. When he uses ‘church’ with a small ‘c’, he refers to every Christian believer regardless of denominational affiliation. When Yoder uses ‘Church’, he usually directs his comments towards a Christendom approach of Church.

in the service of the Anabaptist/Mennonite Church; only secondarily did he want to make a contribution to the larger ecumenical discussion. Yoder's participation within the ecumenical conversation occurred in his contributions on issues of Christian social ethics, peace and reconciliation, and ethics and theology. Yoder's greatest concern for his own life and ministry was to be a faithful disciple in the way in which he followed Jesus' message of peace and non-violent justice. This concern is clearly evident in all of his publications, but most poignantly in his *The Politics of Jesus*.

Even though a 61 page comprehensive bibliography speaks volumes about Yoder's extensive scholarship, he is recognised first and foremost for this seminal work on the possibility of a messianic ethic of Jesus, the Christ. It is in this work that we find the focal point of his understanding of servanthood. Moreover, in this book he clearly represents his methodological approach and thesis statement: the claim that "Jerusalem can relate to Athens, and that Bethlehem has something to say about Rome."³²⁶ In other words, Yoder wanted the scriptures to be relevant in the discussion between the church and the state, and he insisted that the interpreting community was the chosen vehicle for his scholarship. He firmly believed that the church - which for him was constituted by all followers of Christ in spite of denominational affiliation - has a significant voice and social mandate in the social and political market place.

The radical Protestant axiom...according to which it is safer for the life of the church to have the whole people of God reading the whole body of canonical Scripture than to trust for enlightenment only to certain of the filtering processes through which the learned folk of a given age would insist all the truth must pass.³²⁷

In the Radical Reformation interpretation, Yoder did not support the idea of mediated interpretation of the Scriptures. Communal discussions of scripture are already theological interpretations of the gathered believers and thus become the precursor to all ethical and moral conduct of the church in the world. The community of believers does not need an interpretive hierarchical Church to meditate the understanding of scripture. In an attempt to gain a better understanding of his intricate thought patterns, we now need to investigate Yoder's thoughts on service and stewardship, and on caring and compassion. Servanthood is inextricably linked with the place of the church in the world, with the kind of social community that the church is, and also with the understanding of God's coming kingdom. Yoder's three

³²⁶ Yoder, J. H. *The Politics of Jesus*. 3-4.

³²⁷ Yoder, J. H. *The Politics of Jesus*. 4.

components of community, ecclesiology, and eschatology cannot be separated but must be kept in working relationship in order to gain a complete picture of his ideas about the quality of servanthood of God's people in the church and in the world.

i. Yoder's Spiritual and Biographical Journey

Yoder experienced community rootedness himself through his years of growing up in a traditional Mennonite community.³²⁸ In a very similar pattern to that of the physicians in Chapter IV, he was a participant observer for most of his adolescent years. In 1949, as a 22 year old College graduate, he began an assignment with the Mennonite Central Committee in France, where his primary responsibility was to oversee a network of children's homes.³²⁹ In this role, he embodied the gospel of Christ in his own right. As a young adult in a voluntary overseas assignment, he practised the theology of service, which he was taught at Oak Grove Mennonite Church in Ohio. His administrative responsibilities also provided connections with the International Mennonite Peace Committee where he soon became a regular contributor of scholarly articles to ecumenical discussions. From 1954 to 1957 he was responsible for the MCC relief programs in Algeria through the Mennonite Board of Missions and Charities, while at the same time being a full time graduate student at the University of Basle, receiving a Doctor of Theology in 1962.

While Yoder was the administrator for MCC and for the Mennonite Board of Missions, and while he was practising his Anabaptist theology of service, he also continued to write scholarly articles. In 12 years of service and study in Europe he wrote approximately 144 articles, book reviews, scholarly and popular essays, several books, and a number of unpublished papers.³³⁰ The great majority of these articles were written for Anabaptist/Mennonite publications. It seems as if Yoder understood his work to be first and foremost for the service of his own denomination. After receiving his doctorate in Basle, and on completion of his service assignments with MCC, his focus moved towards education. For many years he taught at Goshen College in Goshen, and at Associate Mennonite Seminary in Elkhart in Northern Indiana; only later in life did he receive a call to the University of Notre Dame as Faculty of Theology.

³²⁸ Thiessen Nation, "John H. Yoder," 10-13. All information for the following biographical sketch is in reference to Mark Thiessen Nation's essay on John Howard Yoder.

³²⁹ Mennonite Central Committee is the largest relief and service organisation of the world-wide Mennonite Church. Cf. <http://www.mcc.org/> and also the webpage of the Mennonite World Conference <http://www.mwc.org/>

³³⁰ Thiessen Nation, *Comprehensive Bibliography*. 13-20.

ii. Servanthood and Ecclesiology

Servanthood is not a position of non-power or weakness. It is an alternative mode of power. It is also a way of making things happen, also a way to be present. When we turn from coercion to persuasion, from self-righteousness to service, this is not a retreat but an end run. It brings to bear powers which, on balance, are stronger than the sword alone:

- ◆ the power of truth rediscovered when obscured,
- ◆ the power of the dissenter willing to suffer,
- ◆ the power of the people to withhold confidence,
- ◆ the attraction of an alternative vision,
- ◆ the integrity that accepts sacrifice rather than conformity to evil.³³¹

It is impossible to divorce Yoder's understanding of servanthood from his concept of the church. The Anabaptist interpretation of church, as discussed in Chapter IV, section A, is most closely connected to two Christian concepts: firstly, it is intimately connected to the soteriological significance and ethical ramifications of the life of Jesus Christ, and secondly, servanthood is theologically intertwined with the eschatological telos of the church. Just as Yoder does not separate the Christian church from her founder, Christ, so he refuses to disconnect the Christian church from her eschatological significance. Christ, the suffering servant has implemented the new social order of the new kingdom: servanthood rather than lordship.³³² This, according to Yoder, is the revolutionary idea of Christianity, and when this idea of servanthood is implemented by the believing community, the kingdom of God has already begun, and with it a "messianic social ethic is practised".³³³

The *soteriological significance* of Christ is twofold. On one hand, *Christus Victor* has overcome the principalities and powers of this world, and has thus set humanity free to overcome the state of natural fallenness.³³⁴ Since humanity now has the option to become freed from sin through "justification by grace through faith," we are enabled to turn from self-centred egotism and independence to service for others and interdependence with others.³³⁵ On the other hand, this 'being-set-free-of-self' brings with it the question of allegiance. If the person is freed from personal and structural sinfulness, which is the sign of, and present state of our natural world, and if the person pledges allegiance to Christ and the Christian community through

³³¹ Yoder, J. H. *For the Nations*. 191.

³³² Yoder, J. H. *The Politics of Jesus*, 38.

³³³ Yoder, J. H., *The Politics of Jesus*. 13-20.

³³⁴ Cf. Chapter II Part II of this dissertation.

³³⁵ Yoder, J. H. *The Politics of Jesus*. 212-227.

baptism, Lord's Supper, and community participation, will this person then keep living according to the laws of the old order, or is there a new "redeemed" order to live by? In other words, is the Christian not required to shift his/her allegiance from the present political, social, and economic eschaton to the order of the new eschaton? Or to put it differently, is there an ethic for the church and an ethic for the world?³³⁶ If there is indeed a difference in ethics between the church and the world, how does a Christian deal with the different demands for allegiance on his or her life? The question of the different demands will have to wait for an answer until the last chapter of this dissertation, where we will try to outline ideas that could contribute to future research. The scope of this dissertation allows us to answer the above questions only in the limited arena of biomedical ethics, thus necessarily excluding other important areas like politics, economics, and socio-cultural areas.

The *ethical ramifications* of the soteriological impact of Jesus Christ are that "servanthood replaces dominion [and] forgiveness absorbs hostility. Thus, and only thus, are we bound by New Testament thought to 'be like Jesus.'"³³⁷ For Yoder, being like Jesus presupposes that we understand who this Jesus was as a person, but we also need to understand what the main focus of Jesus' ministry was. Since we can only understand Jesus' life and ministry from the Gospel account, it is important for Yoder to use examples of Jesus' life to make his point. Yoder focuses on Jesus' temptation narrative where Jesus was challenged to accept the "Zealot option" of militant fighting but instead denounced violence.³³⁸ He also refused the temptation to become the "welfare king" with an endless bread supply for the starving masses.³³⁹ And Jesus finally refused the temptation to "let the cup pass" and slip away to the pious, but socially oblivious, community of Qumran.³⁴⁰ Instead, through non-violence, Jesus chose a radically different way of being a servant than that which was the norm for political and military leaders of the time. With the narrative of Jesus' birth and up-bringing, we are introduced to the way in which the kingdom breaks in: from the bottom up rather than from the top down. Finally, by giving up his life, Jesus pointed towards a paradigm shift in servanthood that focuses on 'dying for the

³³⁶ For a current discussion on how to live as a Christian with the demands of different allegiances, see Part III of James Wm. McClendon, Jr, *Witness: Systematic Theology*, Vol. 3. 309-383. Richard B. Hayes, *The Moral Vision of the New Testament: A Contemporary Introduction to New Testament Ethics* (San Francisco: Harper San Francisco, 1996). See there particularly Part Three: "The Hermeneutical Task: The Use of the New Testament in Christian Ethics". 207-312.

³³⁷ Yoder, J. H. *The Politics of Jesus*. 131.

³³⁸ Yoder, J. H. *The Politics of Jesus*, 56-58.

³³⁹ Yoder, J. H. *The Politics of Jesus*. 34-36.

³⁴⁰ Yoder, J. H. *The Politics of Jesus*. 46.

other' as "concretely alternative way to be God's Servant, in both corporate and individual personhood."³⁴¹

iii) Servanthood and Eschatology

The *soteriological telos* of the church can be found in the simple question, what is the church for? Is the church just a place for Jesus' disciples to gather and proclaim that she once had a founder by the name of Jesus Christ? Or does the church have a greater mandate than carrying on a name and a tradition? According to Yoder the "Christian community is the instrument of God's action in the world".³⁴² In other words, the church today, which includes every denomination that confesses Christ as Lord, is the extension of the liberated exile community Israel. Just as God liberated that community from the bondage of Pharaoh and set them as an example for "all the nations" (Exodus 6:2-8; 14:13-14), so the world-wide church today is the example through which the Creator God will reveal himself. Just as God called the Israelites away from the old laws of bondage and submission (Exodus 20; Deut. 5), and established a new covenant with his people in the *Shma Israel* (Deut. 6), so God calls the church today to allegiance with himself rather than with the "kings of this earth". In Yoder's understanding, Jesus' way of peace and reconciliation represents the continuous invitation to enter the kingdom of God and become a new creation (2 Cor. 5:17), to become "a people of the new covenant". (1 Peter 2:9-10). For Yoder, the people who are a part of this new covenant live under new laws, the laws of forgiveness, non-violence, and servanthood, and so become "the new humanity as pulpit and paradigm".³⁴³ Yoder's thoughts on servanthood could be summarised as follows: servants have chosen to follow a master and become thus a community of like-minded believers. This community lives according to the rules of the master, whereby it fulfils two significant functions: first, the community actively proclaims its beliefs in word and deed (the pulpit), and second, the community is passively an example to the surrounding society of what God intends to accomplish with his creation (the paradigm).

If servanthood should become the paradigm with which the physicians of this study wish to practise their professions, we need to ask practical questions about how the concept of pulpit and paradigm is embodied in the lives of the physicians? What will it mean for the physicians to 'proclaim' the good news of God's reconciliation?

³⁴¹ Yoder, J. H. *For the Nations*, 86.

³⁴² Yoder, J. H. *Politics of Jesus*. 147-153.

³⁴³ Yoder, J. H. *For the Nations*. 45-48. Cf. Particularly Chapter 2.

How can such proclamation be done without violating professional boundaries and ethics? How can the physicians, as individuals and as a professional body be the paradigm for God's action in this world? If servanthood should become the manifestation of the physician's beliefs, where in their lives and careers can we find the practical examples? Moreover, are the motivations with which the physicians practise their professions of any notable significance for the development of an Anabaptist/ Mennonite medical ethics? Even though the practical questions of servanthood need to be asked here, for reasons of coherence the answer will have to be deferred until Chapter VI. In order to complete the thoughts of John Howard Yoder, however, we need to ask next about the motivation for the servanthood that the physicians embody in their daily practice.

B) Peace and Non-violent Justice as *modus operandi* for Servanthood

As we have seen in Chapter III, section IV, the motivation with which the physicians practise medicine is vitally important in their careers.³⁴⁴ As an integral part of a church teaching which has formed their character and virtues, peace and non-violent justice is a topic that needs significantly more inclusion in their medical practice, said many of the interviewed physicians. We need to keep in mind that physicians are only a very small fraction of Anabaptist/Mennonites who conscientiously practise peace and non-violent justice in their careers. Mennonites try to embody the same convictions of peace and non-violence in many different professional capacities such as teachers, farmers, professors, engineers, etc. It will be the task of the final chapter to work out how peace and non-violent justice can become the *modus operandi* for the Mennonite medical doctors. Our task now is to understand Yoder's argumentation for the inclusion of peace and non-violent justice in Anabaptist/Mennonite theology and ethics.

In keeping with his Anabaptist fore-parents, Yoder argues as follows for the vital necessity of peace and non-violent justice as the way of discipleship. Firstly, baptism on confession of faith "proclaims an order in which Jew and Gentile, male and female, slave and free have been reconciled not by being homogenised but by accepting one another".³⁴⁵ Secondly, entering the new eschaton of God through baptism, the Lord's Supper becomes the sign of sharing with the body and

³⁴⁴ Chapter III, section IV, part B. 82-87.

³⁴⁵ Yoder, J. H. *For the Nations*. 29.

commitment to the body of Christ.³⁴⁶ Thirdly, the way in which to live in this new community is with forgiveness, love of one's enemy, and peace and reconciliation.

Jesus directed his followers to forgive one another as God had forgiven them. He even told them how to do it, instructing them in procedural detail. Forgiveness was a person-to-person process, not a priestly prerogative... What authorises [the rule of Christ] in the Gospel account is the presence of the Spirit of Christ; whom the community forgives, God has forgiven.³⁴⁷

The rule of Christ to which Yoder points us here is the centre piece of the Sermon on the Mount (Matt. 5:38-48). In Matthew 5: 21-48, Jesus lists a number of rules in the form of six antitheses. Each thesis is introduced with the familiar '*you have heard that it is said to you*' ... but then it is countered with Jesus' '*but I say to you.*' The first set deals with murder and anger, and it challenges the reader to make peace with the neighbour, which is both a result and a consequence of having peace with God (5:22-26). 5:27-30 are the theses-antitheses of Jesus' love requirement to honour marital boundaries with our neighbour and not to violate marriage vows. Likewise, Jesus challenges the divorce regulations of the old law, which left women vulnerable and unable to sustain themselves in ways other than by marrying again (5:31-32). Jesus' interpretation of the old law of oath-taking is such that in the rule of Christ no oath should be taken at all (5:33-37). And finally, Jesus negates the *lex talionis*, the law of retaliation: do not retaliate, do not act to settle a score, and do not insist on your rights (5:38-48). *If you love those who love you, what reward will you get? Are not even the tax collectors doing that? And if you greet only your brothers, what are you doing more than others? Do not even pagans do that?* (5:46-47). This verse contains the challenge of peace and non-violent justice as Yoder and the Anabaptist/Mennonite physicians understand it, and want to embody it in their lives and careers. Modelling a different way from the *lex talionis* is to become a "people of peace, a royal priesthood, and a chosen generation" (1 Peter 2:9-10).

Where conventional wisdom says there must be winners and losers, a peacemaking church looks for negotiated settlements that guard the dignity of each party. Where conventional wisdom focuses on punishing and humiliating wrongdoers, a peacemaking church seeks for ways to restore broken relationships between offenders and victims. Where conventional wisdom dictates that violent revolution is the only way to break the bonds of oppression, a peacemaking church engages in symbolic demonstration to create an opening for nonviolent change,

³⁴⁶ Yoder, J. H. *For the Nations*. 31-32.

³⁴⁷ Yoder, J. H. *For the Nations*. 30.

says Richard Gardner in the *Believers Church Commentary* on Matthew.³⁴⁸

Anabaptists have seen themselves as a peacemaking movement, therefore the question of the social and political relevance of this church is of utmost importance. How can peace and non-violent justice be embodied in a society that does not believe in the same interpretation of peace and non-violent justice as Anabaptists do? Is it indeed viable to declare peace and non-violent justice the *modus operandi* for an entire denomination?

Yoder seems to think that peace and non-violent justice are indeed vital markers of a church that is enabled to live shalom in this world by God's gift of the Holy Spirit. Such shalom is not only limited to the local community or a nationwide denomination: Yoder reminds ecumenists that the entire Christian community of this world "represents an agency of peacemaking in ways often underestimated".³⁴⁹ The notion that the world-wide church is an underestimated peace-making agency seems to be the opinion of the physicians as well. One mentioned an "increasing militancy of health care professionals, even doctors sometimes going on strike".³⁵⁰ He argued that it is a difficult for him to support such militancy particularly because of his Anabaptist peace-making position. Another physician suspected that the problem of secular physicians is that they are "have[ing] a difficult time dealing with issues like forgiveness, and [the place] where death fits into the human life experience".³⁵¹ Anabaptists and other Christians who embody peace and non-violence justice become signposts on the way to wholeness that is motivated by a conviction of peace-making: personal wholeness, wholeness for communities, wholeness for nations, and even striving for wholeness of the entire planet.

In the peace and non-violent justice discussion we find another Anabaptist/Mennonite 'hot topic', the issue of truth-telling or plain speech (see above, Matthew 5: 33-37). One physician who practices in a largely Amish community links peace and truth telling very closely together.

I guess being pacifist, [the importance is] you shall not kill, that type of thing, then the Ten Commandments, being truthful...Again, that's something you were taught from early up. But then I think later that's been taught, but taught

³⁴⁸ Richard B. Gardner, *Believers Church Commentary: Matthew*. (Scotdale, PA: Herald Press, 1991) 114.

³⁴⁹ Yoder cited by Michael Cartwright in John Howard Yoder, *The Royal Priesthood: Essays, Eschatological and Ecumenical*, Michael G. Cartwright (ed) (Grand Rapids: Eerdmans, 1994) 3.

³⁵⁰ Interview # 4, p. v, lines 198-199.

³⁵¹ Interview # 10, p. v, lines 206-208.

black and white. But then I think later on, in medicine it's not always quite that clear. And yet in medicine the policy still holds 'to tell the truth'.³⁵²

Not only is truth telling intricately connected to peace and non-violence, but it is also related to justice, including the question of how to administer and to live justice as an individual Christian and a Christian community. One physician states the issue in his own words, words that could become a challenge in the development of a Mennonite medical ethics.

[P]acifism, relating forcefully in justice concerns. I'm quite involved with my cousin who has just come out of Iraq. That is really highlighting some of the issues that we as Mennonites have to deal with in terms of rank, social justice, and our acquiescence, quietness, about the issues. Justice is more and more [a] key concern for me in the dilemma of the uninsured. That really has driven me to do what I do now, I think it is a terrible injustice what we're dealing with in the US.³⁵³

This physician's observations bring us to a final point that Yoder makes about the churches' responsibility to and involvement in the affairs of the state.³⁵⁴

For Yoder, peace and non-violent justice cannot be achieved without the churches' eschatological telos (see above in this Chapter, A/3). He states three reasons for the churches' necessary focus to be peaceful, non violent, and just. The first reason is that every Christian is called to pacifism, because in Yoder's opinion, "pacifism is not the prophetic vocation of a few individuals".³⁵⁵ Pacifism and peace are an intrinsic element of discipleship in Anabaptist/Mennonite theology, as we saw in Chapter IV, section I/A. Secondly, Yoder insists that peace and reconciliation begin with the individual's confession that Χριστός κΰριος, Christ is Lord, not Caesar or any present political system. That means, that through baptism a person has willingly changed allegiance to the primacy of the lordship of Christ. However, even though a Christian confesses Christ as Lord, the state still has its ordering function. "The reign of Christ means for the state the obligation to serve God by encouraging the good and restraining evil."³⁵⁶ The Christian cannot disregard the state but needs to live with the tension between the ultimate challenge of Christ and the authority of the state. Thirdly, by doing the work of peace and non-violent justice, the church becomes a prophetic witness to the state, according to Yoder. By being such a prophetic, peaceful, and just witness to the state, the church is

³⁵² Interview #9, p. ii, lines 64-69.

³⁵³ Interview #7, p. iii, lines 101-106.

³⁵⁴ Yoder, J. H. *Royal Priesthood*. 158.

³⁵⁵ Yoder, J. H. *Royal Priesthood*. 158.

³⁵⁶ Yoder, J. H. *Royal Priesthood*. 158-159.

responsible for speaking to the state's "methods of warfare and indiscriminate use of military powers".³⁵⁷ It needs to be clear that the church can only be such a prophetic voice because she "combines forgiveness with repentance," and because the church stands in the prophetic tradition of the Old Testament prophets "who spoke of concrete injustices" to their political leaders.³⁵⁸

With this prophetic and paradigmatic approach to the church's task, Yoder could be charged with creating a sectarian option to church. Such a charge, however, could only be substantiated if Yoder's active role in the ecumenical dialogue is not seriously considered. As we have seen in part I, section A of this chapter,³⁵⁹ Yoder's scholarship has all but challenged the church to be the church. Yoder challenges the world-wide church of Jesus Christ to be total disciples of Christ without compromising her position through involvement in political systems, because if the church is too enmeshed with politics it will lose its power and credibility to speak prophetically to the state.³⁶⁰ Yoder's definition of church, though, has yet to be determined in the following discussion of his thoughts on community. We will now investigate the theological foundation of the involvement of community in the development of an Anabaptist medical ethics.

C) Community as *Forum* for Servanthood and Peace and non-violent Justice

As briefly referred to in section B above about the rule of Christ, the community of believers is the appropriate forum for servanthood, and peace and non-violent justice. We need to clarify here that Yoder has never interpreted the community of believers as a sectarian, reclusive option.³⁶¹ On the contrary, his 'community of believers' transcends national, ethnic, or gender identity, and socio-economic boundaries.³⁶² He uses the term church (with a small c) to point to the community of believers, as opposed to the Church (with a capital C), which was

³⁵⁷ Yoder, J. H. *Royal Priesthood*. 159-160.

³⁵⁸ Yoder, J. H. *Royal Priesthood*. 160. Cf. Yoder's discussion with H. Richard Niebuhr in *Authentic Transformation: A New Vision of Christ and Culture* by Glen Stassen, H., Yeager, Diane, M. Yoder, John Howard, (Nashville: Abingdon Press, 1996). 31-89.

³⁵⁹ Cf. 130-138.

³⁶⁰ Cf. Neil Blough, "Geschichte und Theologie im Werk John Howard Yoders," in *Jesus folgen in einer pluralistischen Welt: Impulse aus der Arbeit John Howard Yoders*, by Hanspeter Jecker, (Hrsg.) (Weisenheim am Berg: Agape Verlag, 2001). 23-61.

³⁶¹ Yoder distinguishes church from community in a similar way to Barth. The English language however, does not allow the same distinction between church=Kirche, and community=Gemeinschaft, Gemeinde. In both, Barth's and Yoder's thought, Kirche denotes the Staatskirche, such as the Protestant, Catholic, or Reformed Kirche, whereas Gemeinschaft is used for the gathered group of believers.

³⁶² Cf. Yoder's discussion on 'sectarian' vs. 'public' in *For the Nations*. 40-45 ff.

involved with the politics of the Constantinian project. Reviewing his enormous body of publications on ecumenism and just war discussions leads the reader to believe that Yoder indeed worked actively towards the implementation of a church that transcends nation, gender, ethnicity, and socio-economic limitations. However, this is not the primary focus of this section. Here we need to investigate his interpretation of community from the following angles: firstly, we need to understand the hermeneutical task of the community in interpreting religious scriptures. Then, we need to see how Yoder understands the formative task of the believing community. And finally, we will try to investigate the prophetic task of the community of believers. All these tasks need to be understood as two overlapping circles where the church is placed in the middle part, where the kingdom of this world and the kingdom of God overlap. Because Yoder understands the community of believers to be part of the “kingdom already begun but not yet fully consummated,” we need to investigate each of these tasks for their internal and external functions.³⁶³ If our present interpretation of Yoder is correct, then it is the churches’ task to remain at the point of this intersection with all its tensions and difficulties of being in the world but not of the world (John 17: 14-18). We need not revisit the Anabaptist/Mennonite understanding of how this community of believers is constituted by baptism and the Lord’s Supper. This has already been done in Chapter IV, section I, and in the early part of Chapter V of this dissertation.

1. The Hermeneutical Task of the Community of Believers

Yoder understands the hermeneutical task of the community to be a conversation.³⁶⁴ This conversation is conducted among equals (see section B above) because individuals who are reconciled with Christ are equals. This conversation is conducted according to a certain pattern. There are firstly, *agents of direction* who provide the prophetic direction or vision for the community’s tasks. The direction they provide is recognised, weighed, and ratified by the entire community. Then there are *agents of memory*, “scribes of social knowing”, who ensure that the stories told are consistent with the story of the past.³⁶⁵ *Agents of linguistic self-consciousness* (διδασκοιοι) are those agents who remind the community of its own story in the midst of rival narratives. And finally, there will be the agent of *order and due process*. This agency refers to bishops, elders, shepherds, moderating teams, and

³⁶³ Finger, *Christian Theology*: Vol. 2 Chapter Ten: “The Commission of the Church.” 247-2170.

³⁶⁴ Yoder, J. H. *The Priestly Kingdom*. 28.

³⁶⁵ Yoder, J. H. *The Priestly Kingdom*. 32.

most often “appears in the New Testament in the plural”.³⁶⁶ Such interpretation certainly does not happen in a cultural or socio-economic vacuum. The hermeneutic community rather becomes the place where believers gather to make sense of their embodiment, in the church and in the world.

The hermeneutical circle is the internal conversation in the community of believers that becomes Yoder’s locale for moral education. This is the place where moral choices are learned, where ethics is developed, and where character can grow. Because the community has the potential to practise forgiveness, enemy love, and servanthood first within the community of believers, the individual members are prepared and able to practise these moral and ethical markers outside of the immediate community as well. In an attempt to make sense of human experience, the individual then comes back to the community to ‘debrief’ such experience with other members, and the conversation begins anew. In this sense, the community of believers becomes the first point of reference for the individual in their development of social space. We find similar patterns of reasoning in the social science writing of Pierre Bourdieu, and in the philosophical hermeneutic of Hans-Georg Gadamer.

Bourdieu’s social theory seems to revolve around the term *habitus* which for him is the prime locus from which one understands and perceives one’s world.³⁶⁷ *Habitus* precedes disposition, which is the place of “position taking, the choices made by social agents in the most diverse domains of practise”.³⁶⁸ Out of *habitus* grows a certain disposition and that disposition triggers a particular choice. Only when a choice is made, and as a result of that choice, can one distinguished one’s choice from that of another person’s.

The idea of difference...is at the basis of the very notion of *space*, that is, a set of distinct and coexisting positions which are exterior to one another and which are defined in relation to one another through their *mutual exteriority* and their relations of proximity, vicinity, or distance, as well as through relations of order, such as above, below, and *between*.³⁶⁹

In essence, Bourdieu says that only when one knows his/her *habitus*, or, place of residence - intellectual, religious, and social residence - can one come to see another person’s dis-position (another person’s position) and engage with it. My own disposition/choice can only be understood when it engages with another

³⁶⁶ Yoder, J. H. *The Priestly Kingdom*. 33.

³⁶⁷ Kaessler, Dirk, *Klassiker der Soziologie 2*, (Muenchen: Verlag Christian Beck, 2000.) 257. Cf. Pierre Bourdieu, *Practical Reason*, (Stanford University Press, 1998).

³⁶⁸ Bourdieu, *Practical Reason*. 6.

³⁶⁹ Bourdieu, *Practical Reason*. 6.

disposition/choice, and it is in such engagement that we begin to understand our own uniqueness as distinctive from another's. Bourdieu has developed this idea of differentiation and disposition at length in studies of social and economic spaces.³⁷⁰ He also used similar patterns in his ethnographic observations on the agricultural crisis and social structures in Algiers.³⁷¹

Bourdieu's 'habitus-ethics-distinction' does not seem essentially different from Yoder's claim that there is not that much difference between 'public' and 'private/particular', when he says "there is no 'public' that is not just another particular [private] province. We need a communal instrument of moral reasoning in the light of faith precisely to defend the decision-maker against the stream of conformity to his own world's self-evidence".³⁷² In fact, Yoder challenges the church to be the place with a "thick particular identity, because only then does she have something to say to whatever 'public' is out there".³⁷³ He is very clear that we can only be truly cross-cultural when we accept and embody our particular disposition and choice, when we have a strong identity. Only with a strong identity are we able to recognise the different identity of the other. Only in conversation with a person from another disposition can we recognise our own position.

In other words, accepting another person's origins and the forces that have shaped another person is vital to our ability to accept another person's disposition. Yoder does not seem to advocate the dissolution of different communities, he rather seems to advocate, with Bourdieu, that only by knowing the particular Other can we really know the particular self/us. The trouble is, Yoder says in "Meaning after Babble," that the church needs to learn a "valid trans-community communication, which is a constitutive component of the call to the witness of Christianity after Pentecost".³⁷⁴ Yoder wants the church to move with her own particular communication to a point where she can communicate with others without fear of losing her particular Christian identity. The problem of communication brings us then to the question of interpretation or hermeneutics.

For Hans-Georg Gadamer, on the other hand, the circular structure of understanding is nothing else but a double challenge with which the interpreter has to

³⁷⁰ Bourdieu, *Practical Reason*. 19-63.

³⁷¹ Bourdieu, Pierre, *Sociologie de l'Algérie*. (Paris, 1958).

³⁷² Yoder, J. H. *Priestly Kingdom*. 40.

³⁷³ Yoder, J. H. *For the Nations*. 42.

³⁷⁴ John Howard Yoder, "Meaning after Babble: With Jeffrey Stout beyond Relativism." JRE 24:125-137, 1996. 137-138.

reckon continuously.³⁷⁵ He does not want a theory to be applied in practice in a categorical sense, but he asks the reader to use the theory as a means to “correct the self-understanding of the commonly assumed meaning”.³⁷⁶ In this sense, text becomes the challenge of a long assumed tradition. In the community of believers, Christian scripture - or other sacred texts for other religious communities - becomes the measure according to which Christian praxis needs to be interpreted. According to Gadamer, the problem in this circular interpretation is that interpretation needs to be aware of, and not unduly influenced by, sudden ideas and common knowledge (*Einfälle und Volksbegriffe*). “Every proper interpretation must focus on the matter as such, and must shield itself against the arbitrariness of ideas and the limitations of unidentified thought structures.”³⁷⁷ This means, the practice of Christian believers must be interpreted in light of the scripture which they claim to practise, and should not be unduly challenged by arbitrary ideas or unidentified thought structures.

The second challenge that the text posed to the interpreting agents is not to be stuck in a preconceived idea of the text and its use of language. Gadamer insists that the term prejudice - from Latin *praejudicium* - has a double meaning. Prejudice in the negative sense means that a pre-judgement has been cast without all the facts, or in Gadamer’s case of textual interpretation, with too many preconceived ideas about the text. Positively stated, *praejudicium* can become the precedence case according to which all other cases are judged.³⁷⁸ A similar statement of precedence can be found in Yoder’s understanding of the community of believers. The community of believers, formed through the practice of baptism, the Lord’s Supper, and enemy love has become the precedence case on which the creator God wants to reveal his original intentions: to live peacefully and prophetically as servants who practise forgiveness. In this sense the church has a double mission: to *be* a new humanity, that is, on one hand, to be *pulpit* in proclaiming God in word and action. And on the other hand, the church as the new humanity *is* to be the *paradigm* on which God will reveal God’s intentions and goals.³⁷⁹

The hermeneutical task for the community of believers then is twofold. First, the community of believers needs to remain in a continuous challenging dialectic with the text they interpret. Through this challenge, the church will better understand

³⁷⁵ Gadamer, *Wahrheit und Methode*. 250. [translation by the researcher].

³⁷⁶ Gadamer, *Wahrheit und Methode*. 250.

³⁷⁷ Gadamer, *Wahrheit und Methode*. 251.

³⁷⁸ Gadamer, *Wahrheit und Methode*. 255.

³⁷⁹ Yoder, J. H. *For the Nations*, 37-50. Chapter 2.

her reason for being, her particularity, and her mission. The second task of the community of believers is to identify with the habitus that forms her ethics and gives rise to her disposition. Through such an identification the church can then understand herself through the disposition of and with the other community. The challenges, if we understand Yoder right, are that the community of believers learns to communicate with another community so that neither community loses its self-identity, but also in a way that makes meaningful communication possible. The hermeneutical task of the community of believers becomes then another task, the formative task.

2. The Formative Task of the Community of Believers

The formative task of the community of believers has already been alluded to in the previous point. Formation of identity - which in its broadest sense is physical, emotional, spiritual and intellectual - happens in a particular habitus. This habitus can be in a variety of cultural or ethnic settings that do not stifle the core entities of servanthood, enemy love, and forgiveness of the community of believers. From this habitus a certain ethos develops, an identity of who we are as a Christian people. Yoder ingeniously likens this point to the Diaspora setting of the Jews in Babylonian exile.³⁸⁰ The habitus is not necessarily a physical place, such as the synagogue or the church, it is an ethos or a process that “enables the creation of a faith community with a globally new gestalt”.³⁸¹

Yoder describes this process in six distinct, but interrelated steps of the Jewish community in exile. There is a) a local cell of a few people who b) gather around c) the text in worship with, if they can afford it, the help of a scribe (see above C1). Visitations, intermarriage, commerce and Rabbinic consultations keep the exile community d) internationally connected. Next, e) the walk of the common life, called halakah, shapes the Jewish identity by remembering the shared story. And finally, f) all these steps together enable the exile community to be “comfortable and creative in dialogue with whatever Gentile world it lands in”.³⁸² This description of the habit-forming shape of the Jewish exile community is also a very good illustration of Yoder’s term “trans-communal communication”. The exile community does not lose its Jewish identity by living in a foreign land. Their identity is rather

³⁸⁰ Yoder, J. H. *For the Nations*, Chapter 3: “See how they go with their faces to the sun”. 51-78.

³⁸¹ Yoder, J. H. *For the Nations*. 58.

³⁸² Yoder, J. H. *For the Nations*. 59. See also Yoder’s article “Walk and Word: The Alternatives to Methodologism”, in: *Theology without Foundations: Religious Practice and the Future of Theological Truth*, by Hauerwas, Murphy, and Nation. (Nashville: Abingdon Press, 1994). 77-90.

strengthened by the constant trans-communal communication and interaction with 'the Other'. Incidentally, one could try to apply Yoder's interpretation to any Jewish community around the world today, and it would be fascinating to develop a comparative study with other exile communities, such as the Armenian people. However, such a comparison not part of this dissertation.³⁸³

Identity and character formation occur when everyone member is a vital part of the community. In the case of the Mennonite community, participant observation and embodiment are vital aspects of the hermeneutic community. As we have seen in Chapter IV part B, Anabaptist/Mennonites put great emphasis on participation and embodiment even in their very early Confessions of Faith. The physicians of this study have told us about a similar pattern of identity formation in their interviews in Chapter III, part IV B. Another splendid example is Mark Metzler Sawin's article "Moving Stubbornly toward the Kingdom of God: Mennonite Identity in the Twenty First Century," where he examines the theological, social, and cultural aspects of the identity question.³⁸⁴ He points out that religious identity has as much to do with our personal location in social space as it has to do with our arrangements and practice of religious rites. Such identity formers, as he calls religious rites, become boundary markers that make 'us' who we are. Boundary markers are imperative, because "to feel a part of a group, one needs to feel different from those who are not a part of that group".³⁸⁵ Sawin observes that Mennonite cookbooks, quilts, furnishings and poetry could be interpreted as physical manifestations of the "creation of a globally new gestalt" of this particular Anabaptist community. It needs to feel different to be a Manitoba Mennonite than it feels to be a Scottish Presbyterian. However, Yoder's important point is that trans-communal communication happens when both communities dialogue with each other on a level that transcends culinary specialties, culture, and customs. Identity formation is then not dependent on geographic location, intellectual affiliation, or material acquisitions. Identity formation is to know the habitus/ethos which informs one's choices and leads to one's ethical and moral embodiment. It is here that Barth is right

³⁸³ Biographical sidebar: I had the opportunity to live close to, and watch the Jewish Community when I lived in Basle, Switzerland, and Yoder's explanations do ring true with my observation in 1991 in Basle. The Armenian, Hmong, and Hispanic communities in California where I lived from 1993-1998, display a similar pattern of identity formation.

³⁸⁴ Metzler Sawin, Mark, "Moving Stubbornly toward the Kingdom of God: Mennonite Identity in the Twenty First Century", MQR:1, January 20001, 89-98.

³⁸⁵ Sawin Metzler, "Moving Stubbornly toward the Kingdom of God", 95. Cf. Steve Nolt, "A 'Two-Kingdom' People in World of Multiple Identities: Religion, Ethnicity, and American Mennonites", MQR:3, July 1999, 485-502.

to insist that “to be human is to act, and to act is to be ethical”.³⁸⁶ According to Barth, the rightness or wrongness of such ethical actions needs to be measured against the ultimate ethical example, Christ.

As communities of believers, Anabaptist/Mennonites meet around hermeneutic interpretation of the word of God, and by following this process their Christian identity is formed. But this hermeneutic interpretation does not only form, it also challenges the community of believers to become active and understand its place in this world. According to Yoder, the church is not only pulpit and paradigm, it also has a role to play in society at large, and it is this prophetic role we turn to in our last point about the place of community in the thought of John Howard Yoder.

3. The Prophetic Task of the Community of Believers

The prophetic task of the community can be best described in its internal and its external role. Both of these tasks in turn need to be understood in their passive and active voice if we try to describe a complete picture of the community of believers according to Yoder’s interpretation.

The *active internal* task of the community has already been discussed at length in the previous two points. The community takes active part in the hermeneutical work of interpreting scripture, and the community also has an active role in the formation of identities - physical, emotional, spiritual, and intellectual. The latter task of the community focuses on the individual agent but also on its own corporate life as a church.

The *passive internal* task has been discussed previously as well, namely under point one of this section. It can be described as being the habitus where a particular ethos can be observed, experienced, and embodied. The passive task of the church is to be the proverbial training ground where the individual agent can test his/her ethics and particularity with like-minded agents. This testing ground is necessary for the preparation of the individual agent to competently enter into other communities without being in danger of losing his/her identity in the process. By being an egalitarian community, as the early Christian community is called to be in Galatians (3:28), the believing community actually displays what other communities could also achieve: reconciliation with God and each other, and to the capacity to live in peace with and service to one another. Another *passive task* of the believing community is, according to Yoder, to “be an alternative community by being now what the world is called to be ultimately: a foretaste of peace for which the world

³⁸⁶ Barth, *Kirchliche Dogmatik*, Vol. IV/36. 574.

was made".³⁸⁷ By being such a peaceful community, which can exemplify what God is all about, the *passive internal* task of the believing community overlaps with the *passive external* task.

The *passive external* task is defined by Yoder as a "paradigmatic pattern of recognition".³⁸⁸ If the community of believers can display patterns of recognition for other communities to observe - such as harmony between races and gender, harmony between different national and economic agents, and justice that begins with the greatest concern for its weakest members - then the apostolic witness of redemption can be observed in action. Then, in a paradigm shift, violence and retaliation could turn into peace and enemy love, then domination and power could turn into servanthood, and hatred could turn into forgiveness. When the church takes its passive external task seriously, then the church exemplifies its "sacramentality...and represents the kind of society that all of society ought to be".³⁸⁹ When the community of believers fulfils this passive task, it stands in direct succession to the Exodus community (Exodus 6:5-8), and to the exile community of Jeremiah (Jer. 29:7, 11-14; chapter 31), and it becomes as such the redeemed new people of 1 Peter 2. However important, this passive external task of the community of believers is not enough, according to Yoder.

The *active external* task of the believing community is to have a prophetic voice that drives us into active social concern...The Christian community does things which the world may imitate. The Christian community feeds the hungry and cares for the sick in a way which may become a model for the wider society. The Christian community makes decisions through group process in which more than one participates, and moves towards decision by consensus rather than by virtue of office and authority.³⁹⁰

Yoder's theological basis for much of the Anabaptist/Mennonite practice of service to the world is commonalty of ownership. The community of believers owns the hermeneutical process by embodying a particular ethics in the world. In his writing Yoder challenges not only his fellow Mennonites *to be* the believing community, he also challenges other Christian communities to be more faithful to their call. The prophetic voice and active social concern will be embodied in all areas

³⁸⁷ Yoder, J. H. *Priestly Kingdom*. 93-94.

³⁸⁸ Yoder, J. H. *For the Nations*. 43.

³⁸⁹ Yoder, J. H. *Priestly Kingdom*. 93.

³⁹⁰ Yoder, J. H. *For the Nations*. 183-185.

of the wider society, but this dissertation has focused on how Mennonite physicians have embodied the above described challenge in their careers.

Yoder's intricate thought processes do not allow us to separate the complex connection between servanthood, peace and non-violent justice, and community. Such a division has been created for the sake of this dissertation and in order to collect the thoughts of the physicians under workable headlines. In the workshop entitled "Medical Ethics and Anabaptist Theology," one participant pointed to exactly that problem by saying that it is impossible to be a servant without the sustaining and supportive community that reminds the individual about his/her commitment to peace and non-violent justice.³⁹¹ This observation succinctly summarised not only the essence of the writing of John Howard Yoder, but also the reflections of the physicians in this study.

Before we can critically engage with the thought of John Howard Yoder, we need to state his opinion on another important area that emerged from the interviews, in order to find congruence between his teaching and the embodied practice of the physicians. To establish a more complete picture of Yoder's writing, we need to recover what he has contributed to the emerging themes with philosophical-ethical content.

II. EMERGING THEMES WITH PHILOSOPHICAL-ETHICAL CONTENT

As a reminder of the emerging themes with philosophical-ethical content, we need to recall the analysis in Chapter III, section IV/B briefly. The first theme we found there was centred around the question of separating faith from ethics. The physicians have clearly stated, that it is impossible for them to separate what they believe theologically from what they do in their medical practice. The second theme revolved around questions of tolerance. What can I, what ought I, as a Mennonite physician do when my patient insists on treatment that I cannot provide with a clear conscience? What ought I as a Mennonite physician do when my patient cannot afford a treatment that is clearly indicated? The physicians related this question to issues at the beginning of life, and also to the prolongation of physical existence at the end of life. The first topic of separation of faith and ethics has already been discussed in Chapter II and in the first part of this chapter, so we will only briefly refer to it here. The second issue, which we will name tolerance, will therefore

³⁹¹ Mennonite Health Assembly, March 22-25, 2001, Albuquerque, NM. See also: MHJ, 3:2 April-June 2001. 17.

become our focal point in this section; tolerance refers to the early Anabaptist/Mennonite tradition of tolerance.

A clarification of the term ‘philosophical’ is necessary here. ‘Philosophical’ does not refer to either existential philosophy or analytical philosophy. Neither does it indicate any correlation with any philosophical system discussed so far. Philosophical here denotes simply thinking about one’s theoretical basis for the sake of knowledge.

A) Is there a Separation of Faith and Ethics?

If we have understood Yoder at all so far, we might agree that in his theological reflection it is impossible to separate faith and ethics. He would even go as far as arguing that there are different ethical requirements for the community of believers and for non-believing communities, because the ethics of Christ is meant for the disciples of Christ. But since not everyone confesses to be a disciple of Christ, he/she cannot be held accountable to that Christian standard. In addition to the ‘Christian and non-Christian’ distinction, we furthermore need to be clear that not every Christian will interpret the ethics of Christ the same way as Yoder has in his writings. This line of reasoning can best be illustrated by the example of Yoder’s discussion of H. R. Niebuhr’s work on *Christ and Culture* in the book *Authentic Transformation*.

In the article, “How H. Richard Niebuhr Reasoned,” Yoder tries to understand the methodological reasoning of H. R. Niebuhr’s *Christ and Culture*.³⁹² Yoder’s most fundamental critique is that Niebuhr inadequately defined his meaning of Christ, or the meaning of Culture, and that he therefore came to conclusions that are inaccurate, as well as one-sided. In fact, Niebuhr’s strong leaning towards the transformative aspect of Christ is based on using Christ as “one pole in the dualism” discussion between Christ and Culture.³⁹³ According to Yoder, strong emphasis on the transformative aspect of Christ evades the question of Christ’s lordship. Christ’s lordship over this aeon is questioned on the basis of textual and historical criticism regarding the humanity of Christ, and Yoder charges Niebuhr with inadequate reference to the developments of ecclesiastical history, and Christian dogmatics, and in particular, with a one-sided use of the Trinity.³⁹⁴ In constructing his argument in such a fashion, Niebuhr appears to have been least in sympathy with his concept of

³⁹² Yoder, J. H. “How H. Richard Niebuhr Reasoned. 31-89.

³⁹³ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 41-42.

³⁹⁴ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 34-35, 37-40, 61-65.

“Christ against Culture” and in sympathy with his “Christ transforming Culture”, says Yoder. The next step in the argument leads Yoder to charge Niebuhr with paving the way to an increasingly anthropocentric interpretation of theology and faith, where the question is not Christ’s interpretation of culture but our own interpretation of what culture is and how it relates to Christ, and how Christians relate to culture:

Jesus has become in sum one of the poles of a dualism. It is we, the modern practitioners of Christian ethics, who shall judge to what extent we give our allegiance to him and to what extent we let his critical claims be conditioned by our acceptance of other values, within the culture, which He in principle calls us to turn away from. We also are in charge of defining the other pole of the dualism. We manage our own epistemology. We are the moderators in charge of the balancing process... We have the last word, Christ does not. Jesus is very important; Lord he is not, if “Lord” denotes an ultimate claim.

This makes clear in turn why the dialogue with Niebuhr is important for continuing Christian moral discourse. What is at stake is the whether, and the how of Christ’s being Lord.³⁹⁵

After stating his principal claim that Christ has been inadequately presented by Niebuhr’s argument, Yoder goes on to dissect Niebuhr’s interpretation of culture. Culture becomes monolithic and is assumed to be “a single block,” culture is defined independently of Christ, and lastly, the state becomes prototypically representative of culture, according to Yoder.³⁹⁶ According to Yoder, it is flawed thinking to equate culture with state, and since one cannot easily define what the majority opinion is, it is imperative to have a guiding measure for one’s moral and ethical discernment other than culture or state. After culture has become identical to state, says Yoder, a consequent step will be to see who is pro-state and who is against it. As a test case for this question, Yoder recalls Niebuhr’s treatment of pacifist Mennonites, who, in reference to their convictions, refused military service. Because they elected not to serve the state through military service, Mennonites have been grouped in the *Christ against Culture* section.³⁹⁷ What Niebuhr did not see, or could not see in the situation, was the fact that most of the Conscientious Objectors were serving in State Mental Hospitals or other medical services, social services, or overseas relief work.³⁹⁸ Refusal to serve one’s country in the military cannot be equated with refusing to serve one’s country at all. Mennonite Christianity has long been understood as

³⁹⁵ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 43.

³⁹⁶ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 54-55.

³⁹⁷ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 55-58.

³⁹⁸ Cf. Calvin Redekop, *The Pax Story: Service in the Name of Christ, 1951-1976*. (Scotdale, PA: Herald Press, 2001).

Christianity from the grass roots, and since “Christ against Culture” does not describe the attitude of mainstream Christianity, a grass-roots or “sectarian” faith approach would also not be found in “Christ transforming Culture”. Any alternative approach to mainline Christianity would therefore be negated as religiously exclusive, socially inept, and intellectually underdeveloped. In mainstream Christianity only the majority faith approach counts. This is indiscriminate acceptance of religion, according to Yoder, and needs to be more defined.

Yoder finally expands on his argument that the Christ of the Bible does not seem to have the same “lordship” status as the Christ of mainstream Christianity. “The Christ who is Lord is inseparable from the Christ who is human,” Christ’s humanity was a cultural reality in Nazareth.³⁹⁹ The disciples follow Christ in a given culture, confess the Lordship of Christ over principalities and powers, and discriminate between those aspects of culture which the disciples of Christ can or cannot support. Yoder classifies aspects which need to be rejected (pornography, tyranny, cultic idolatry), those aspects which can be accepted with limitations (economy, arts, taxes), those aspects which receive new motivation and meaning through Christians who serve in them (literacy, conflict resolution, empowerment), and lastly, cultural aspects that are created by the church (hospitals, general education, abolition of slavery).⁴⁰⁰ Following Christ in all aspects of life is what makes the Christian a Christian, and for Yoder, being a Christian means to make Christ and the New Testament the main narrative for one’s measure of moral and ethical decisions.

This distinctness of the church from the rest of society means that Christians will be making their moral decisions on grounds which not all men and women apply. The appeal to Christ which gives form to their decisions must then not be measured by whether all will follow it, or by projecting what would happen if they did...It is this specificity of the church as a new phenomenon within the history, sharing the uniqueness of the Incarnation as humanly as possible in obedience, which seals the impossibility of reasoning as if “culture” were a “monolithic” unity. The call for “transformation” can only have substance if there has already been some modelling of that to which the hearers are called.”⁴⁰¹

We see here that Yoder has dealt with one of the most crucial charges against Anabaptist denominations, namely that of sectarianism. The historian of religion, Ernst Troeltsch, who authored *Social Teachings of the Christian Churches*, might

³⁹⁹ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 68.

⁴⁰⁰ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 69.

⁴⁰¹ Yoder, J. H. “How H. Richard Niebuhr Reasoned.” 75.

have been a significant influence on Niebuhr's *Christ and Culture*.⁴⁰² However, Yoder's point needs to be taken seriously, that Niebuhr did leave himself open for criticism by leaving his interpretation of Christ rather undefined. Niebuhr also seems to have presupposed too many unspoken assumptions regarding the relationship of Church and State and the question of authority over the individual agents in his/her community. But the biggest problem for Yoder is Niebuhr's uncritical acceptance of a so-called 'mainstream Christianity,' which Yoder sees as closely associated with the democratic process of the USA and with an increasing search for metaphysical morals and ethical absolutes.⁴⁰³ It appears impossible in Yoder's theology to be ethically convinced in a metaphysical sense, but not embody such ethical conviction in one's daily life. Since we have already dealt at length with the question of separating faith and ethics in this chapter, we will now have to proceed to understand Yoder's interpretation of the Anabaptist ideal of tolerance, an idea without which Yoder could not have been engaged in the above discussion, as well as in many of his other ecumenical writings.

B) The Question of Tolerance

The question of tolerance is the second heading under which the philosophical musings of the Mennonite physicians have been summarised. One of the physicians mentioned specifically the Anabaptist practice of religious tolerance in the 16th century.⁴⁰⁴ Others have alluded to tolerance with their reflections on the appropriate procedure when a patient insists on a different, and sometimes controversial, medical treatment. Religious tolerance in Yoder's writing is perhaps best understood through his publications on ecumenical issues and through his activities and speaking engagements in a variety of denominational settings.

The general question of tolerance has to be understood against the background of religious tolerance in particular. This religious tolerance is something the early Anabaptists of the 16th century had to deal with when they decided to separate themselves from Zwingli's Reformed Church of Zurich in 1525.⁴⁰⁵ Although the term "free churches" was introduced much later in the history of the church, it has been the early Anabaptist's two-fold insistence that the church should not be bound by any forces: neither by magistrates who exerted political pressure on

⁴⁰² H. R. Niebuhr wrote his dissertation at Yale in 1924 on *Ernst Troeltsch's Philosophy of Religion*.

⁴⁰³ Cf. Wells, *Transforming Fate into Destiny*, Chapter 1. 2-12.

⁴⁰⁴ Interview #4, p. viii, 338.

⁴⁰⁵ Ulrich Gabler, *Huldrych Zwingli: His Life and Work*, trans. Ruth C.L. Gritsch (Edinburgh: T&T Clark, 1986). Cf. Particularly Chapter VIII, "Conflict about the Sacrament." 125-139. See also Chapter II, section I/A of this dissertation.

the individual members via church government, nor by papal forces which exerted ecclesial pressures via top-down interpretation of scriptures and administration of sacraments.⁴⁰⁶ William Penn took this idea of religious tolerance and liberty to Pennsylvania where he founded a state based on religious freedom, equality, and tolerance.⁴⁰⁷ Penn's founding of Pennsylvania and the settlement of many early Anabaptists in this state might have a close correlation. But this thought needs to remain another idea for a future project. Yoder insists that church happens where the community of believers gather around the Lord's table and where the community of believers act in servanthood rather than domination, in peace rather than with force, with enemy love rather than with retaliation. Where this happens, national boundaries, ethnic identifications, socio-economic status, and gender distinctions can be effectively dealt with by appropriate "trans-community communications". Wherever such trans-community communication is practised effectively, tolerance is implemented and ecumenical dialogue established.⁴⁰⁸

Yoder's ecumenical work spans several decades. It began when he was a young MCC volunteer in France, and he remained active in ecumenism for the rest of his career. Ecumenism and inter-religious dialogue were the issues close to his heart. Because this is not the place for an in-depth study of Yoder's entire ecumenical engagement, it shall suffice to summarise his basic thoughts on ecumenism. However, we will see that his understanding of ecumenism is inextricably linked with his ecclesiology, which, in turn, is indivisible from his understanding of eschatology. For Yoder, the church of Jesus Christ - wherever she meets around the Lord's Supper, and wherever she practises peace, servanthood, and enemy love - is the physical manifestation of the new aeon, the new eschaton. This church of Jesus Christ is not inhibited by our artificially established denominational divisions, it much rather overcomes denominational trench wars, and is thereby a truly ecumenical church of Jesus Christ. We have discussed Yoder's theological understanding in detail in this chapter in section I C, but also in Chapter II, where we discussed the developmental factors of such an Anabaptist/Mennonite theology. In

⁴⁰⁶ James, Wm. McClendon, "The Voluntary Church of the Twenty-first Century" in *The Believers Church: A Voluntary Church* by William H. Brackney, (ed) (Kitchener, ON: Pandora Press, 1998). 182.

⁴⁰⁷ Yoder, J. H. "How H. R. Niebuhr Reasoned," 86. It would be interesting to conduct a study of the influence of Anabaptist theology on religious tolerance in the early years of the founding of Pennsylvania.

⁴⁰⁸ Yoder, J. H. "Meaning after Babble," 137-138.

Yoder's understanding, such a church is a Believers church, and such a church concept can be a truly ecumenical concept.⁴⁰⁹

Tolerance towards each other is the necessary vantage point from which one can engage in ecumenical dialogue. If there is no tolerance for another point of view or theological interpretation, how can communication be maintained? Moreover, if one has not adequately defined one's point of view, how can one tolerate another person's theological interpretation? One's theological interpretation is for Yoder the epistemological result of one's habitus (see Bourdieu above), in which, and out of which, one's ethics proceeds. In other words, and perhaps in more yoderian terms, the *where* of one's life (geographical, social, and economic space) and the *how* of one's life (servanthood or coercion, enemy love or retaliation, peace or violence), are determining factors of one's *theology and ethics* (the embodied outworking of one's physical, spiritual, emotional, and intellectual being). Once habitus is understood in relation to the other, and once that habitus has been 'owned' by the agent and/or community, then "trans-communal communication" is possible, desirable, even necessary for existence.⁴¹⁰ Tolerance becomes then the vital focal point for religious dialogue, since without tolerance one would not be able to accept the other point of view. A crucial prerequisite for tolerance however, is for Yoder the knowledge about, and acceptance of one's own position, which is formed by the habitus in which one is located.

It seems as though tolerance in Anabaptist understanding is more than just validating another point of view and leaving each other alone. Tolerance in Anabaptism includes the willingness for and ability to keep the dialogue open in spite of differences. It could be argued that the lack of tolerance on the part of the 16th century Reformers cost many early Anabaptists their lives. Tolerance includes openness to the other position, but also sensitivity about the audience one is dialogically engaged with. According to Michael Cartwright, such openness was Yoder's speciality.⁴¹¹ Yoder not only embodied translatability for English speaking audiences, furthermore, he also had the ability to present the same ideas in lectures in several different languages. Tolerance derives its meaning from the Latin 'tolerare,'

⁴⁰⁹ Michael Cartwright in Yoder, J. H. *The Royal Priesthood*, 27. 'Believers church' today denotes denominations in the Anabaptist tradition, such as all shades of Mennonites, Church of the Brethren, Brethren in Christ, and variations of Quakers. Cf. Callen, *Radical Christianity*. The term Believers church was first coined by Max Weber in his *Protestant Ethic and the Spirit of Capitalism*, trans. T. Parsons (New York: Scribner's Sons, 1958).

⁴¹⁰ Yoder, J. H. "Meaning after Babble," 132-134.

⁴¹¹ Cartwright in Yoder's *Royal Priesthood*. 32-33.

which denotes endurance, or to endure. Yoder's life and work seem to exhibit just that, to be continually exposed to the ecumenical dialogue without giving up the ideal of trans-communal communication.⁴¹² This ability seems to indicate that it was imperative for him to insist on continued relationship and communication much more than on being right.

Tolerance as a result of continued presence and relationship also seems the most vital observation of the interviewed physicians. None of them seemed to be willing, either for material gain or for ideological reasons, to sever the relationship with their patients. This conviction has become a decisive point of view in three distinct areas of biomedical ethics today: the abortion question, issues surrounding equal access to health care, and the whole array of questions surrounding the end of life. All three of these issues will be the focal point of the last chapter in this dissertation, therefore it will suffice to quote only one example from the interviews regarding the question of tolerance.

Getting older, I'm not quite sure if some of it is ageing or some of it is also faith, but I tend to be [a] little less legalistic, probably years ago I would have had more clear answers in that case, you know the highest rule is you don't abort, period, there is nothing to talk about. Whereas you know, particularly in my situation in Mississippi, really getting to struggle with people who are poor, people are subject to a lot of the evil of our society, you're a little less easy to say there is only one way in God's eyes to do things, and you better do this or else. But walking with people, so if the woman finally comes to say you know "I really need to abort this pregnancy", then I would walk with her. I might feel uncomfortable doing an abortion myself, I probably would, I don't think I could do it, I certainly would not reject a person who chose that. The person who chose that, I would point them a way to go to find a safe place to get it done, and then would welcome them to come back and continue to walk with me.⁴¹³

In this case of the abortion discussion, continued presence with the patient, even through severe differences of opinion, seems to be much more important to the Mennonite physicians than the patient's adherence to the physician's recommendation. Tolerating the patient's decision for his or her medical treatment does not diminish the wish of this physician to support the patient on the path of wholeness. He sees this as one mark that distinguishes a Mennonite physician, or even MMA as a whole, from other professional bodies such as the CMDS.

I think it is part of our AB position, maybe that is why we have our own Medical association, because we do see some differences that make us

⁴¹² Yoder, *Royal Priesthood*, Part III. 221-322.

⁴¹³ Pilot study interview #2, p. iv, 125-136.

different. I was a member of both CMDS and MMA, but I'm no longer a member of CMDS, and I often felt a lot of their ethical positions were a bit more legalistic than I was comfortable with.⁴¹⁴

Being present with, coming along side of, and supporting the patient towards the goal of wholeness is a direct result of the physicians' reflections about their theological and ethical habitus and its ethical result on their medical practice. The physicians related tolerance, as did Yoder, to theological interpretation and to their ethical self-understanding. Whether in inter-religious and ecumenical dialogue, or in the physician's practice, trans-communal communication can only occur when both sides are aware of their point of view, and are committed to continuous dialogue.

Conclusion to the Chapter

In this chapter we have discussed the pertinent issues that the physicians emphasised in the analysis: servanthood, peace and non-violent justice, and community. By investigating the thoughts of John Howard Yoder in the attempt to find his opinion on these issues, we found that he is deeply committed to the same issues, albeit in a more theoretical and methodical way. We also found similarities between the physicians' theological and ethical development in Chapter III and Yoder's theological and ethical development. Participant observation and embodiment have been forming factors in Yoder's life and a guiding sign-post for his academic work. He practised what he preached, and preached what he had experienced, not only as a volunteer early on in his life, but also as a seminary professor and an active conversation partner in the ecumenical movement.

Theologically we found that Yoder's understanding of the community of believers is inextricably linked with his ecclesiology and his understanding and interpretation of eschatology. Because Christ called the disciples to live under a new law, the law of servanthood, enemy love and peace making, the community of believers sees themselves as the new people of God and as such, an extension of the called out believers of the Exodus story. This community of believers is not limited by any of the artificial boundaries we as humans place on ourselves, such as nationality, race, socio-economic status, or even biology. Because this community can be inclusive and egalitarian, it has the ability to practise trans-community communication. Only in communicating in such a way, according to Yoder, can we really fulfil our calling as a church and become the good news for the world.

⁴¹⁴ Pilot study interview #2, p. vi, lines 222-226.

Yoder is not an easy theologian to deal with in his writings, nor was he an easy scholar to be around, but his thoughts are nonetheless invaluable for our quest to understand Anabaptist/Mennonite theology and ethics. In his time, and in his life's work, he applied Anabaptist/Mennonite principles to peace and reconciliation, to disarmament, to questions of nuclear power, the cold war, and in the ecumenical dialogue. He was a relentless opponent of just-war theory, and a perpetual challenger and defender of the churches' social responsibility. However, it is the task of the last chapter of this dissertation now to connect the Anabaptist/Mennonite principles of servanthood, peace and non-violent justice, and community to questions in biomedical ethics. We will ask first how servanthood can serve as a model for the physicians in questions of the beginning of life, in questions of the end of life, and in questions of justice in health care. We will then have to discover how peace and non-violent justice can be used by the physicians as an operating mode with which they can approach those questions. And lastly, we will see how community can be a place of sustenance for the physicians who fulfil their professional role with such intentions.

CHAPTER VI

APPLYING THE EMERGING THEMES

Virtue, then, is a state of character concerned with choice.

Aristotle, *Nicomachean Ethics* 1107a

Introduction to the Chapter

In this chapter we are finally required to provide a constructive correlation of the emerging themes of the *empirical research* among Anabaptist/Mennonite physicians. For a better understanding of the themes, we will begin with a brief review of the research findings. In Chapter II we were introduced to the beginning of the data collection, emphasising the initial email contacts with Anabaptist/Mennonite physicians and a brief preliminary demographic data collection. The volunteers were asked to briefly comment on three case studies.

The first case study was concerned with the question of an abortion of a troubled and socially unstable mother of three, who was pregnant as a result of rape. We found an interesting response to this case study. Even though all the Mennonite physicians were in principle against abortion, they all emphasised one crucial factor: all five email respondents emphasised that they would not end the relationship with this patient even though she might decide differently from themselves about terminating the pregnancy. It appears that continuing the relationship with the patient is of utmost importance for the Anabaptist/Mennonite physicians. Such emphasis locates the Mennonite physicians between their more dogmatic colleagues in the more evangelical physicians' organisation, CMDS, and the more liberal physicians, who would not make their personal opinion known to the patient at all.

The second case study was concerned with an end of life issue, and the case of Mr. Brophy was chosen.⁴¹⁵ Here the physicians were asked to comment on Mr. Brophy's request to end his life as a PVS victim after an accident. Mr. Brophy had made this request clear to his family long before he was seriously injured in a work-related accident. Mrs. Brophy had to fight the American hospital and legal system for nearly two years before Mr. Brophy's wish to turn off life support machines was finally granted. Reflecting on this case the responses of the physicians seem to indicate another important Anabaptist/Mennonite precept. In these answers the

⁴¹⁵ Cf. Chapter II, p. 43; see also the case study in Appendix A, pp. i-iii.

Anabaptist issue of peace and non-violence emerged. The physicians asked questions about the value of life, when life ends, what constitutes the quality of life, and how this quality is measured; other questions were the issue of autonomy of the patient, the blessing and curse of modern medical technology, and questions surrounding the relationship of the physician and patient (and his/her family) in cases of termination of life. Peace and non-violent justice appeared as another particular Anabaptist/Mennonite principle from the initial email responses. On this issue we found an emphasis on relationship again, but this time the focus was on finding a common conclusion about when it is appropriate to release life.

The last case for the physicians to comment on was a case of genetic counselling.⁴¹⁶ The responses to this case were very varied in the sense that the younger physicians declined to answer the case on grounds of limited medical experience. The two email responses that were supplied came from two senior Anabaptist/Mennonite physicians. One is a retired paediatrician, the other a retired gynaecologist. Both were very thoughtful in their responses, questioning the validity of a pregnancy that will result in the birth of a severely handicapped child. Email respondent # 1 even consulted with a geneticist about this case and clearly indicated that he would not advise the couple to go ahead with a pregnancy that would end in producing another severely handicapped male child.⁴¹⁷ In this response we find that issues surrounding community discernment, community support, and community involvement in the life of the couple seem to be a very important focus for the Anabaptist/Mennonite physician. In addition, we find questions surrounding the use of resource allocation, and again, the issue of the physician-patient relationship.

In a second step of the research, we were then introduced to the interview volunteers who make up the pilot study. The pilot study was done to probe the interest of the physicians in the development of an Anabaptist/Mennonite biomedical ethics. Both of the interview partners clearly indicated the need for such a specific approach; it also seemed that the physicians' reasoning about, and rationale for such an Anabaptist approach to biomedical ethics emerged from their rootedness in the Anabaptist/Mennonite theological tradition. One crucial issue emerged from the pilot study: the concern of both physicians to ensure that younger Anabaptist/Mennonite physicians are supported and encouraged to enter this profession with a strong sense of vocation. This vocation is to be embodied through a variety of emphases, but the

⁴¹⁶ Cf. Appendix A, p. iii.

⁴¹⁷ Email Response # 1, p. i-ii, lines 38-64.

most dominant of them are servanthood, peace, non-violence, advocacy, and an emphasis on community and tolerance. With these encouraging findings we were then ready for the final step in this empirical research, namely the main body of interviews.

In the last step of the empirical study, 10 research interviews were taped at the Annual Meeting of the Mennonite Medical Association in Waterloo, Canada in June 2000. While the researcher was a participant observer, 10 volunteer subjects answered five semi-structured interview questions. The analysis of the interviews showed strong congruency with both the email responses and the pilot study interviews. Three dominant themes emerged from the main interviews: first, there is *servanthood*, which is a term that encompasses *service, stewardship, compassion and caring*. These terms were of paramount importance for the physicians in their self-understanding as Anabaptist/Mennonites.⁴¹⁸ Next, we found reflections on the attitude that is to guide the physicians in their vocation. Here another theme emerged: the Anabaptist question about *peace and non-violent justice* was introduced by the physicians. They reflected on the necessity of including the Radical Reformation peace witness in biomedical ethics, but could not support this reflection with cases from their practice. However, it seems that peace and justice are heavily emphasised as the motivational attitude with which the physicians want to practise their trade. How this particular peace and non-violence emphasis of the Radical Reformation can be included in questions of contemporary biomedical ethics needs to be determined in this present chapter. The last emphasis of the Anabaptist/Mennonite physicians seemed to revolve around the question of the *involvement of the community* in biomedical ethics. Here it appears that the question is twofold: on one hand we find thoughts about the place of the community in the process of decision-making for the patient. On the other hand, however, we find the physicians wondering what kind of support the church community can be to them in their often very stressful and demanding professions in medicine.⁴¹⁹ Besides these, more theologically based themes, we also found thoughtful philosophical responses which revolved around issues of tolerance of life style of the physician, as well as tolerance in the physician-patient relationship.

After the introduction to the empirical research in Chapter II and III, it was imperative to introduce Anabaptist theology to set the empirical work in its

⁴¹⁸ Cf. Chapter III, pp. 61-65.

⁴¹⁹ Cf. Chapter III, pp. 67-69.

theological and ethical perspective. In Chapter IV we discussed the historical background of Anabaptist/Mennonite theology and ethics. This background work focused on the forming and moulding influence of Anabaptist/Mennonite confessions, particularly *Confession of Faith in a Mennonite Perspective*. This *Confession* is the most current working document of Mennonite Churches in the USA and Canada. While researching the *Confession*, we found close similarities between Anabaptist/Mennonite theology and the findings of the empirical research. We found a particular pattern through which the individual seems to learn about theology: the inextricable connectedness between observation, participation, and embodiment seems to be the unifying process through which the theological and the empirical research connect. We also found our themes of servanthood, peace and non-violent justice and community emerging again in the *Confession*. These themes run like a common thread through Anabaptist/Mennonite theology and ethics and appear to be the most defining elements of modern Anabaptist/Mennonites.

In order to support the empirical and theological findings further, we subsequently investigated the scholarship of John Howard Yoder in Chapter V. In this chapter, we tried to find evidence in Yoder's scholarship that would support the thesis of this dissertation, that there is indeed a unique and particular contribution of Anabaptist/Mennonite theology that should be integrated into contemporary biomedical ethics. The themes that have emerged in the empirical research with the physicians, and which are also important themes in Anabaptist/Mennonite theology, have been validated in Chapter V.

In this last chapter it is now necessary to put the findings into operation with actual issues in contemporary biomedical ethics. This will be done in three distinct, but inter-related sections. In section I of this chapter, we will discuss how servanthood can be a model for the physician in questions of the beginning of life, in questions of the end of life, and in questions of justice in health care. In section II we will investigate the *modus operandi* of peace and non-violent justice in the same three issues in biomedical ethics. If the physicians want to practise servanthood, will there be a significant impact if they emphasise peace and justice? How is the Mennonite physician's understanding of justice different from the understanding of justice in the *Principles of Biomedical Ethics*? Is it actually viable to emphasise peace and justice in questions such as the beginning of life, end of life, and justice in health care? In section III of this chapter we will apply the finding of the primacy of community to the very same questions of the end of life, beginning of life and health

care justice. What kind of impact could the community have on these questions of biomedical ethics? Can the Church community actually be a place of sustenance and sending for the physician and for the patient? If so, what would such a church community have to look like? If a church community cannot be such a forum, what would have to change for a community to become such a sustaining and sending forum?

I. SERVANTHOOD AS *MODEL* FOR PHYSICIAN CONDUCT

Since it is logistically impossible to treat every bioethics issue related to questions of the beginning of life, the end of life, and justice in health care in this last chapter, we will focus on only a few issues that have emerged throughout the entire empirical research. To each of the proposed sections, I-III of this chapter, we will begin with interview excerpts of the physicians. Then we will engage in a debate between contemporary biomedical ethics and the excerpts of the interviewed physicians. At the end of each part we will state the unique Anabaptist/Mennonite emphasis that could be added to the discussion of contemporary biomedical ethics.

A) Questions of the Beginning of Life

At the beginning of this part we need to remember that the term ‘servanthood’ in this dissertation denotes four distinct sub terms. Service, compassion, caring, and stewardship have been important issues that the physicians mentioned as expressions of their vocation as medical practitioners. For most of them, becoming a physician had not been just a choice, most of the volunteers can distinctly remember being clearly called to be a physician, a healer. Service, compassion, caring, and stewardship were used interchangeably by the physicians to describe their understanding of servanthood; therefore, in this section, we will use these terms interchangeably as well.⁴²⁰

We also need to be clear about another important fact of the empirical research. There seems to be a tendency by the Mennonite physicians to work as General Practitioners, or at least in a specialised area that still provides a lot of patient contact. Over half of the physicians of the demographic study are primary care physicians who only later in their careers specialised and branched out in different fields.⁴²¹ However, there were no volunteers from the area of medical research, and only two from the area of disease control, even though there well may

⁴²⁰ Cf. Chapter III, Section I/B, p. 62-65.

⁴²¹ Cf. Chapter II, section IV/C, p. 56.

be Anabaptist/Mennonite physicians working in areas of scientific medical research. It is a crucial point to consider that the Mennonite physicians put great emphasis on the quality of care they provide; for many volunteers in this study, such quality of care includes an open and strong physician-patient relationship where time and communication are vitally important factors in that relationship.

1. Questions of Physician-Patient Relationship

The physicians of the study seem to put most emphasis on the ways in which they care for their patients. The attitude of the physician seems to be of equal importance to his/her skills of healing. For the Anabaptist/Mennonite doctor, a competent and highly qualified practitioner also needs to be of virtuous character, approachable, sociable, and communicative. In Chapter II and Chapter IV, we were introduced at length to the participant-observation-embodiment cycle, that shaped the physicians' embodiment of the virtuous characteristics in their personal lives and careers. In Chapter V we have been introduced to the theological framework that gives rise to such an ethical embodiment. The aetiology of servanthood in the discussion of this dissertation is based on the biblical understanding of what a servant is (character), how a servant is required to act (virtue), and what the requirements (habits) for a servant are.⁴²² The ultimate role model for the physicians in this study seems to be Jesus Christ as he is described in the New Testament account, particularly in the Sermon on the Mount. Univocally, the interviews appear to ask for more congruency between the physician's life and practice and Jesus' life and practice.

I don't think it's God's will I'm a doctor, I don't think it's God's will at all. It's God's will of what kind of doctor I should be, and so I'm a big one on choice. I like choices and I think God gives us choices, and that sort of stuff. But the kind of choices is how we relate to people, I think it has to do with caring, has to do with compassion, it has to do with going the extra mile.⁴²³

This physician expresses very clearly that being a servant is a choice, not something that happens to him in a passive way. For him it is a choice to be of a certain character, it is a choice to act virtuously, and it is a choice to exhibit certain habits associated with this character and the virtues. However, this interviewee clarified the need for role models in the formative years (his father) and the need to be connected with the kinds of religious and intellectual influences he grew up with (family, friends, and church). He also points out that being a servant has to do with

⁴²² Cf. Chapter V, section I/A, p. 114-116.

⁴²³ Interview # 2, p. i-ii, lines 43-47.

the choices he makes in his own practice as a physician and as a person in relationship to family and patients.⁴²⁴

Caring genuinely for the patients, having compassion with choices patients make, serving the patients as Christ would serve them, and being faithful stewards with the resources that have been given to them are the hallmarks of the Anabaptist/Mennonite physicians' concept of how servanthood should be modelled in their medical practice. For the physicians in this study, servanthood seems to be a core conviction of what it means to embody Christ in their vocational choice.

Life is about living authentically and living with open hands toward others, and relating creatively in our relationship to God. And having lives that are whole and that are not fragmented or torn apart, or running in a hundred different directions. And my medical profession says that the value of a medical life is being extremely busy, in status seeking, and in making lots of money. All of which just flies in the face of my Anabaptist convictions.⁴²⁵

This physician juxtaposes the demands of his profession very well with his convictions of the character of an Anabaptist/Mennonite Christian physician. His initial medical experience of high earning power and status-seeking was later challenged by his experience in a Voluntary Service assignment on an American-Indian Reservation. Living in these two different worlds culminated in his decision to start a practice for uninsured patients in a rural area in the Mid-Western USA.

Embodiment of conviction seems to be the all-encompassing wish of the physicians in this study. They exhibit a yearning to implement their theologically held convictions more fully with their medical practice as physicians. It would be an impossible task in this dissertation to work out in detail how servanthood should be embodied in medical practice. This will be the task of the physicians themselves, when they read the findings of this research. However, we will now encounter practical examples of contemporary biomedical ethics and we will try to begin to outline the kind of difference servanthood might have in the practice of the physician-patient relationship.

2. Issues in Reproductive Health

It seems that the Mennonite physicians deal with questions of servanthood in the beginning of life from a variety of different angles. One of the primary questions revolves around the issue of the extraordinary efforts and expenditures to achieve

⁴²⁴ Interview # 2, p. ii, iii, iv-v.

⁴²⁵ Interview # 7, p. iv, lines 152-156.

pregnancy. It seems impossible to separate the question of extraordinary effort from issues of resource allocation or from issues of justice in health care.

In general, I take dim view of extreme reproductive technology and feel it has gone much too far. Society doesn't owe me a child. Children are gifts, not a right that someone has to provide for me. The septuplet case is something for physicians to be ashamed of, not proud of.⁴²⁶

This physician is not generally opposed to reproductive technology, particularly since Obstetrics-Gynaecology has been his career. What he is refusing to bow down to, however, is the excessive use of resources in producing the septuplets, and then in maintaining their much too fragile health in the early years of their lives. The physician is referring to the case of a woman in Iowa, USA, who gave birth to seven children after infertility treatment in 1997. For religious reasons, the woman refused to reduce the number of embryos, even though such a reduction had been strongly recommended and even medically indicated.

Another physician has similar questions regarding the excessive use of resources for ART treatment, particularly when such use might be questionable in its survival-cost ratio.

Why do we spend millions of dollars to keep that 18 weeks foetus alive and in Africa there is no choice, that baby dies? And here it makes it to 4 month and then dies, \$ 300'000 later. To me that's a justice issue. When it comes to money, it just doesn't seem right to put all our resources in one person. Why do we save only one person and let millions die?⁴²⁷

These questions are not easy questions and they do need to be answered, particularly in light of continuously shrinking resources. How can the Mennonite physicians be faithful stewards over the resources entrusted to them when they are charged with the care of cases such as these? Is it possible that Anabaptist/Mennonite physicians have a vital contribution to make in the larger discussion around ethical questions of reproductive health? Is it possible that the Anabaptist emphasis on stewardship could provide significant contributions for the restructuring of our health care resource problems?

One paediatrician, who responded to the case studies in the initial email reply took the time to consult with a geneticist at a local Children's Hospital. His very thoughtful response gives us a good insight into the intricate thought pattern of an Anabaptist/Mennonite physician. His response also gives us the first clues about the particular contributions of an Anabaptist/Mennonite biomedical ethics.

⁴²⁶ Email Respondent # 4, p. ii, lines 55-58.

⁴²⁷ Interview # 8, p. iv, lines 163-166, 167-169.

The case study is very interesting to me. First of all, I consulted with one of our geneticists at Valley Children's Hospital (part of the U. C. San Francisco medical faculty.) In a busy service with 3-4 physicians in a field that is changing rapidly, as an Anabaptist physician I use the best consultants available. I was told that there is currently more information about Fragile X on the internet than we could read in three weeks. The information I received in five minutes or so would require in practice a full, extensive consultation. First of all, the problem is not due to the sperm, so IVF with non-parent donor sperm would not reduce the risk of Fragile X. The genetic defect is in the DNA of the ovum, a "trinucleotide repeat", and the number of repeats in the specific ovum determines the severity of the Fragile X. It is variable. Furthermore, it is sex-linked in the X chromosome that is variably affected. Therefore, the risk is only to boys. A girl should not be affected. The geneticist reports that this is high-tech stuff, trying to determine the number of defects, the degree of abnormality in the ovum DNA. My geneticist said she would refuse to implant a known defective embryo. "We have too many genetic abnormalities without knowingly creating more".⁴²⁸

Several reproductive health issues arise from this response, issues that need to be discussed under the heading of servanthood, because the servant-physician will focus on the best interest of the patient and not his/her own. S/he will closely consider the request of his/her patient holistically, including the interest of the child yet to be born. Therefore, the first issue for the servant-physician is that of *information*. The paediatrician took time to consult with a geneticist over the question of Fragile X. In practice, this information will have to be related to the couple who is asking for assistance.

The second issue is that of *time*, and it is closely related to the issue of information. The physician needs to take time out to find information for the patients, to process the information first, and then needs to take time with the couple to relate the information to them so they can understand all the implications. As this case study indicates, information about Fragile X is not something that can be shared quickly or briefly. This information needs to be researched, discussed, processed, and understood in its many implications. A good relationship between physician and patient(s) is based on trust and open communication and is crucial for the health and wellbeing of all the parties involved in a case like the one described above.

Thirdly, we need to consider the issue of *cost*. The initial consultation with the physician needs to be paid for. There will most likely be a consultation with a specialised geneticist, which is an additional cost. Furthermore, it is conceivable that there will have to be physical tests that add to the balance sheet. After those initial tests, there will then be the cost of the treatment, should the couple decide to go

⁴²⁸ Email Response # 1, p. i-ii, lines 38-53.

ahead with the treatment, very much against the advice of the primary physician and the geneticist. The costs so far are only the initial expenses on the road to conception. If the couple indeed goes ahead and have the baby - in spite of the high financial cost and the high risk that a baby boy would be affected with Fragile X - there will also be the cost of long-term care for this severely disabled person.

The fourth issue is that of *physical* and *psychological endurance*. In addition to time and money investments, it needs to be stressed that the emotional and psychological investment in issues of reproductive health is considerable.⁴²⁹ The psychological and emotional stresses of IVF treatment need to be considered as well as the physical strain such treatment brings on a woman. The psychological stress involved in IVF treatment and in raising a child with a severe disability needs to be taken into serious consideration when embarking on a course of reproductive health. If servanthood is an important aspect of the physician's attitude, psychological issues should certainly be a major concern in the ethical discussion about reproductive health in the physician-patient relationship.

The last issue in ART are questions surrounding *racial discrimination*. Except for the now villainous "Tuskegee Syphilis Study", racial discrimination has not yet been widely discussed in biomedical ethics. However, the recent article "Navigating Race in the Market for Human Gametes" in the Hastings Centre Report points to exactly that neglected point of racial discrimination in IVF.⁴³⁰ Hawley Fogg-Davis challenges contemporary biomedical ethics that this "largely unregulated market" of gamete donations is one expression of "racial classifications [that] continues to be a source of social hierarchy, a mark of civic standing, cultural development, beauty, intelligence and subordination".⁴³¹ It appears that no other area of biomedical ethics is as vulnerable to obvious racial discrimination as the racially motivated choice of donor gametes. Fogg-Davis, as well as Naomi Zack, severely challenge biomedical ethics for what they call "race-specific gamete shopping as a publicly sanctioned private institution for breeding white people".⁴³²

⁴²⁹ Cf. Suzanne Holland, "Contested Commodities at Both Ends of Life: Buying and Selling Gametes, Embryos, and Body Tissues," KIEJ Vol. 11, 3:263-284, Sept. 2001. According to the American Society for Reproductive Medicine, the total cost for IVF treatment is estimated at \$7800 in 1995.

⁴³⁰ Fogg-Davis, Hawley, "Navigating Race in the Market for Human Gametes", HCR 31:5, Sept./Oct. 2001, 13-21.

⁴³¹ Fogg-Davis, "Navigating Race in the Market for Human Gametes, 18.

⁴³² Fogg-Davis, "Navigating Race in the Market for Human Gametes, 14. Cf. Naomi Zack, *Race and Mixed Race* (Philadelphia, PA: Temple University Press, 1993). 40.

It is hoped that the servant physician is sensitive to issues of race in the question of ART and IVF. Questions regarding cost, information, time and emotional investment could be a stepping-stone for the physician to see through the veil of racially motivated choice of donor gametes for IVF. Racial equality is a vitally important issue in contemporary biomedical ethics that needs to become a primary issue for future considerations.

Termination of Pregnancy (TOP)

Another issue in reproductive health is the question of termination of pregnancy (TOP). In all areas of reproductive health, TOP will inevitably become part of the discussion. Whether the question is one of terminating a severely handicapped foetus, or whether the question is the timing and/or the circumstances of a pregnancy, TOP is often presented to the woman as an option. No matter what has caused the discussion of TOP between the physician and his/her patient, all options with their positive and negative aspects need to be discussed thoroughly. Stem cell research and its required use of germ lines from blastocysts influences the discussion of the use of terminated embryos. Is it morally permissible to use an aborted foetus for stem cell research? Can a woman who contemplates a TOP withhold consent for the use of her foetus for such research? Should the woman be encouraged to give consent for the research so that the TOP can be utilised positively in future research? The physician who takes servanthood as a role model for his/her practice of medicine will need to engage constructively with his/her patient over such questions.

Moral Status of the Embryo

Besides the logistical questions of time, information, cost, and the psychological effects of TOP, there is the lingering, but ever-present question of the moral status of the foetus. The physician who takes servanthood as the model for his/her professional conduct should be able to discuss this question with his/her patients. In questions of TOP, caring and compassion seem to be at the forefront of the physicians' responses. Included in this attitude of caring is the question of support, of 'coming along-side,' of com-*passion* with the patient and support for her even though the physician does not agree with the decision.

I remember that when I was in family practice... [W]e had a lot of women from the college come to our office with unwanted pregnancies. Well, you know, what do you do? Do you say, "well, no, you shouldn't abort that?" And of course, bottom line they knew exactly what they wanted, they wanted us to confirm the pregnancy, and give them a referral. I usually would try to talk with them about adopting options, tell them where they can go for abortions, well of course, most of them knew that; but [I would also]

welcome them to come back and continue the journey of preventing this from happening in the future. And looking at what that meant for their lives, some of them of course would have the abortions and that was it, they were on. But there would be others, maybe because of their faith background who would struggle with guilt, well, I think we need to struggle with them in their pain. Because you know, I have my sins, they have their sins and we need to struggle together as fellow pilgrims.⁴³³

It seems that for the Anabaptist/Mennonite physician who practises his/her vocation with a strong sense of servanthood, it is not enough to just provide the medical treatment. There is a strong sense of continuing the physician-patient relationship beyond the present medical situation. All of the Mennonite physicians of this study, beginning with the email responses through to the main interviews, have stated their opinion about TOP's in words that are similar to the following:

If she has decided on an abortion, I would try to explore if she has sought other options. If she is adamant, I would not try to stop her from having an abortion. My personal views on abortion would not be made apparent to the patient except in so far as I would not help her to expedite it. I would not try to stop her, because I could not stop her and she would leave my practice. At least if I remain her physician I can hopefully provide a touchstone whereby God may act in her life. Some physicians I know would tell the patient that her desire to do this is immoral and make it clear where they stand. This sort of medicine I have never tried to practise.⁴³⁴

In this statement we find one of the most crucial elements of servanthood that seems to be practised by the Anabaptist/Mennonite physicians. "At least if I remain her physician I can provide a touchstone..." staying in contact, keeping the physician-patient relationship alive, not severing ties that could prove to be life giving, are issues at the core of the Mennonite physicians' self-understanding. The desire for continuous patient relationship appears to be particularly poignant in questions of termination of pregnancy. In this particular issue of biomedical ethics, the physicians of the study seem to understand the need for continuous support for their patients who face such a difficult decision.

B) Questions of the End of Life

Unfortunately, the most money is spent in a person's life so often in the last year, year and half of life, the last illnesses, that type of thing, unless it is sudden death. I would say, when I look at my Amish folks and also from my Anabaptist teachings, if we really believe in afterlife, heaven, all that we talk about, I don't know why, if we really have the facts, why we would still put in so much effort to prolong life, or even prolong death. I think we can learn from them, and if we have the facts [statistical outcome of recovery] I'm not

⁴³³ Pilot Study Interview # 2, p. iv, lines 136-148.

⁴³⁴ Email Response # 3, p. i, lines 33-41.

sure why we prolong life, or prolong death. I think the tough questions come up with Alzheimer's and demented people. How long do you have to keep these people going?

Oh yes, I think its there, I mean with the respect they give to old people and the handicapped who they call their special children, I think they show a sanctity [for] life. On the other hand they don't think it has to be extended to the point of prolong[ing] death. What they understand is they just prolong death, they died back there. I think they have a high respect for life, you know, their old folks are cared for, the special children, babies are wanted and taken care of in their own terms.

Connectedness to earth, understanding the beginning and end of things. Also the children grow up, because of large families, they grow up taking care of others, grandparents live with them, they see death, that type of thing. Birth and death, they're exposed to the whole cycle of life better than what we are, we are so isolated. I think they're better equipped.⁴³⁵

This physician with over 35 years experience of working with the Amish community in rural Ohio does seem to voice the convictions of Anabaptist/Mennonite physicians best. He is one of three interviewed physicians who have extensive experience of health related work with Amish people. He points to several issues that are included in the Anabaptist/Mennonite understanding of servanthood that could become a vital contribution of biomedical ethics. This interpretation of servanthood can have viability in the debate of contemporary biomedical ethics, when it is approached with the three following emphases in mind.

There is first the question of *stewardship of limited resources*. Limited resources is one of the pressing issues in contemporary biomedical ethics. What do we do with increasing numbers of people who need treatment on a decreasing health care budget?⁴³⁶ Further studies need to be conducted to understand the impact of the refusal of health insurance within some wings of the Amish community, but it seems that this community has a more competent grasp on the issues of living with limited resources. From the Amish social construction of life there follows then another important factor, namely, the need for connectedness and mutual aid. It is not only connectedness within, and reliance on the community, this community also appears to have a less fragmented, and more balanced understanding of the cycle of life and our human connectedness with the earth. Limited resources here does not mean limited access to health care or diminished capacity of care-taking, it rather means that we work towards a better understanding of our connectedness to each other. This

⁴³⁵ Interview # 9, p. v-vi, lines 209-217, 258-268.

⁴³⁶ Cf. *Ethics in an Ageing Society* by Harry R. Moody (Baltimore: Johns Hopkins University Press, 1992).

includes a holistically comprehensive knowledge that our current systems of health care is confined by limitations which leave some people without adequate health care. It seems that the honest acknowledgements that there are limits could be the first step towards a creative restructuring of the current systems for the best possible care for all citizens.

The experience of the above quoted physician can be formulated in a second important aspect of servanthood, namely the *stewardship of interconnection*. The Mennonite physicians, and those with Amish experience in particular, highlight the need for biomedical ethics to take seriously the various layers of connectedness of the patients, e. g. psycho-social, economic, religious and intellectual. A physician who tries to practise the stewardship of interconnection knows that his/her patient in the consultation room is more than that particular individual in front of him/her. The patient is the sum total of his/her family of origin, up-bringing, social sphere, educational and professional possibilities, etc. Stewardship of interconnection needs to include also our understanding of the connectedness of humans and the geographical world, particularly in terms of use and waste of ecological resources. From the interview excerpt we can see that the physician who works within the Amish community observes that the members have a better grasp of the complexities of life within that community.

The third important focus of servanthood could be called *stewardship of limitations*. As we see in this excerpt, and as it emerges in this research, Anabaptist/Mennonite physicians are asking questions about accepting limitations. When is it time to accept that life has its end? How do we accept the limitations of a handicapped child? How do we live a life in fullness that considers our neighbour and does not deplete resources for just one person? How do we accept the limitations of medical research without losing sight of the dignity of the patient? Stewardship of limitations, however, has also very practical components, and these components are particularly pertinent to questions at the end of life. When is enough artificial life support enough?

Brophy had already suffered “personal death”, neo-cortical death, and should be allowed to complete his dying. To force his physiological body and keep his breathing when the person is gone, is coercive, violent, and obscene.⁴³⁷

Here again we find the distinction between prolonging life and prolonging death. Anabaptist/Mennonite physicians clearly stress the need for such a distinction.

⁴³⁷ Email Response 4, p. i, lines 42-44. Cf. Case Study on End of life Issues, Appendix A, p. i-iii.

Is the treatment at the end of life prolonging life or is it prolonging death? The stewardship of limitations is squarely situated between prolonging life and prolonging death. It is embodied by accepting the limitations of medical treatment where the dignity of all persons involved is preserved (not only the patient but also the dignity of the family and of the care givers); it is here that responsible use of resources is exercised, and it is in the stewardship of limitations that the physician has the opportunity to embody the virtues on which his/her profession is based. In the context of Anabaptist/Mennonite theology, stewardship of limitations is not a cowardly refusal of medical options; this kind of stewardship rather acknowledged the limitations of medicine, conveys that knowledge to the patient, and courageously works with the patient in accepting death.

1. Withholding Life Support vs. Withdrawing Life Support

Three particular emphases of the servanthood question come to bear on questions at the end of life: caring, compassion and stewardship. We have already discussed the question of stewardship and the need to balance the use of scarce resources. We also talk about stewardship in more detail in the questions of justice in health care below. The main point in issues at the end of life is the care and compassion that is embodied by the physician in relation to his/her dying patient. A physician who embodies servanthood will be clear about our human finitude as a result of the created order.⁴³⁸ He/she will be clear about probabilities of survival and/or recovery, and he/she will be clear, honest, and open in the communication with the patient and family members.

One of my other jobs is I'm chief of staff of our hospital. So I'm appointed by the board, I'm hired by the board to oversee health care and be involved in a lot of the funding discussions. And so where ethics might come in also in the discussion and decision making as an administrator, which is a little different from my actual patient practice.

Ethical discussions, ethical decisions, I think some of the tough stuff is - and maybe its not ethics as much- I think the whole dilemma with terminal care probably. Walking through that, when do you say enough is enough, and working through some of that quality vs. quantity discussions, of saying well, maybe that treatment might give you [a] few more weeks but are they useful weeks for you and your husband, when I think of that breast cancer patient. Those sort of tough things of trying to apply, I don't know. What are some other issues? [This volunteer had the tendency to ask and answer his own questions within the interview questions]

You know, one can talk about terminal care as one of the ones. Is an IV treatment or care? Is water, is food and water treatment or is it care?

⁴³⁸ Cf. Sjoerd L. Bonting. *Mens, chaos, verzoening: Natuurwetenschappelijk en Theologisch Bezien*, (Kampen: Uitgeverij Kok, 1998).

Should you discontinue when someone has had a stroke and is not recovering from that stroke, and they've had an IV put up, is it ok to turn that IV off and let them slip off into dehydration and come to the end? Or are we obligated to provide IV therapy till they die? Am I obligated to treat pneumonia in a terminal patient or should I say, let it be? I guess I compare myself to some of my very evangelical friends who are very strong pro-life. I'm a little more liberal in turning off IVs. I'm a little more liberal in saying to the family "look, lets not do more blood work, I don't really care, (not that I don't care), but what the potassium level is or what the chest X-ray shows really doesn't matter anymore." So I'm more prepared not to treat a terminal pneumonia. Whereas I know some of my evangelical friends would say, "look, you got a pneumonia, you know you got something in your pocket that would treat the particular complication, you should treat that."⁴³⁹

When servanthood is practised in questions of end of life care, compassion and caring will become the foremost issues for the physician. In the context of the Anabaptist/Mennonite physician, compassion and caring includes having empathy and compassion with the suffering patient, and to look how treatment options complete the whole picture of the patient's life. Is the treatment in question really contributing to the overall well-being of the patient or is it only prolonging unnecessary suffering and agony? The question of how professional care can be delivered compassionately needs to be balanced with questions of futility and responsible use of resources. The decision about treatment needs to be discussed honestly and openly between the patient and his/her physician, so that the patient can make fully informed decisions about treatment. Balancing these questions openly in dialogue with the patient must be the foremost concern of the Anabaptist/Mennonite physician who makes servanthood his/her priority.

C) Questions of Justice in Health Care

So far the discussion of the application of the practice of servanthood has revolved around issues at the beginning of life and issues at the end of life. Questions of justice in health care are never far removed from any issue in medicine. In this part, the discussion of justice includes allocation of resources (see A above), it includes access to health care, and it also includes questions about decision-making in health care. Because this is a dissertation about theological and ethical application in health care, the definition of justice in this section will be first and foremost in reference to a biblical-theological understanding of justice.

Another value is stewardship of resources. To use limited resources to keep someone alive who has no hope of recovery seems inconsistent with our belief in stewardship. In addition this is often applied inequitably especially

⁴³⁹ Interview # 2, p. v-vi, lines 259-280.

from a world perspective but even in our wealthy, Western countries. In most countries, Mr. Brophy would have died a long time before he did.⁴⁴⁰

For the Anabaptist/Mennonite physician, the question of justice in health care is inextricably linked with questions of resources allocation. The issue of servanthood is of particular interest in this section, because of the physicians' intricate knowledge and experience of stewardship. Justice in health care is primarily an issue of stewardship over existing resources. Resource allocation touches all areas of health care and should therefore be the prime target of our understanding of justice. In the two previous points we have seen that the expenses in beginning and end of life issues are immense. The newly understood servanthood model for physicians will highlight the inequalities in health care, and will therefore propose a more just and more equitable application of health care. One of the interviewed physicians has taken his understanding of justice in health care to the new and mostly unexplored area of providing health care to uninsured patients. In the following excerpt, he criticises not only his own Medical Association for a lack of involvement in the area of treatment of the uninsured, but he also refuses to be blinded by what he calls "pet issues in bioethics."

Well I know of what drives that discussion [in bioethics] goes back to the pet issues of abortion, euthanasia and genetic engineering, etc. And I'm afraid that an organisation like this [MMA] could get its attention grabbed quickly by those issues. I'm a member of the CMDS, and I'm very dissatisfied that's their definition, that's all they're talking about. I think that we as Anabaptists have a set of much harder questions to wrestle with maybe in some ways, because they hit near and dear to each one of our lives. That is issues of just living, life style, and seeking out elements of injustice in a society, especially things that have to do with health access, we should be putting those in front and centre of our attention, in my estimation. The people who can't access health care should be the top concern of Anabaptists who are in health care. Another troubling issue is our excessive reliance of personal wealth accumulation and what does that mean in terms of authentic living as a Christian. Cause I think the wealth accumulation is a very big thing. I'm not sure if falls under the rubric ethics, I hate to side-track what you're exploring, but that is to me an ethical issue. It involves life style decision making, it involves directing our medical practices. Those are intense theological issues too, where do we put our faith? Do we put our faith and security into our earning ability? Or do we put it into a benevolent God who can take care of us in any situation? But whether that's ethical is a matter of definition.⁴⁴¹

This physician puts his finger on several crucial and intricately connected issues in the discussion around justice in health care. First of all, justice in health care

⁴⁴⁰ Email Response # 2, p. ii, lines 51-55.

⁴⁴¹ Interview # 7, p. v-vi, lines 213-230.

is interconnected with personal life style choices. It seems clear to him that Anabaptist/Mennonite physicians need to be more aware of the implications of their choice of specialisation or the geographical location of their medical practices. Tailoring one's office to well-paying and insurance card-carrying clients will almost certainly leave uninsured patients without access to health care. However, treating patients who are covered by insurance is naturally financially more viable than treating those who do not have any insurance or only limited insurance coverage. The decision to practise the servanthood model will inevitably challenge the physician on the question of life style issues. Anabaptist/Mennonites have been called the 'plain people' in the past for the very reason that outward signs of life style choices (i.e. dress, car, signs of affluence) have been congruent with their belief of trust in God and not in material possessions.

This historical emphasis on reliance on God rather than on material gain brings us to the second point that this physician emphasised. He called it "our excessive reliance on personal wealth accumulation vs. authentic living as a Christian".⁴⁴² It is certainly true that physicians in the US are among those members of society with a very high earning power. It therefore seems to be in their power to make decisions about life style, which in turn can have an effect on the patients to whom they tailor their offices. In the case of this physician, he left a high earning office in order to start a clinic for uninsured patients. Since the clinic does not supply enough money for his and his family's financial needs, he supplements the income with occasional work at the nearby hospital in the emergency room. For him, based on his faith convictions, justice in health care is not only inextricably linked with resource allocation, but also with his personal life style choices.

Thirdly, in the above excerpt, we find also a close link between "life style and seeking out elements of injustice". Seeking out elements of injustice in health care is not restricted to issues such as abortion, euthanasia or stem cell research. The physician who practises servanthood will be aware that injustices in health care are woven in a many-dimensional web of multi-layered problems of injustices in society. The person who does not have adequate access to health care has this problem for many reasons: a) *educational injustice*: because s/he does not have an adequate job which provides health care either through the job or by earning enough money for health insurance premiums; s/he is unable to get this job because of limited access to all educational levels necessary to secure such a job; because of a minority status

⁴⁴² Interview # 7, p. v, lines 222-224.

and/or refugee status, the person does not have the same starting point and support system for an education required to get an adequate job that provides health insurance; b) *social injustices*: the person might be able to access the education necessary for the job, but s/he might be precluded from attending for lack of funds, i.e. funds have to be used for other necessities of life for the family, care for children or elderly/infirm parents, etc.; the person does have an education but works in a job that does not provide health insurance, and the money s/he earns is not sufficient to cover all living costs and the additional health insurance premium; c) *intellectual and emotional injustice*: the person might not be able to work in a high pressure job that provides health insurance and is forced to work on a minimal wage that does not allow extra funds for health care; the constant financial pressure debilitates the intellectual and emotional capacity of the person to see how s/he can get out of this destructive circle of injustice, therefore attaining an education and/or the job that provides health insurance seems virtually impossible.

This is only one layer, and probably the most obvious layer, of injustice in society that precludes some people from adequate health care access. Other layers of injustice have already been mentioned above through the interview excerpts. In order to access the high-cost treatment of IVF, a couple must already be equipped with funds (and/or the jobs to get the funds) before they can ask for such treatment. Is it not an injustice in itself that a society enables some people to have funds for such high-cost treatments while other people in the same society do not have such funds? Another example is pre-implantation diagnostic: before any further decisions can be taken about the health of a foetus, a couple/woman needs to be able to access health care first in order to receive a diagnosis. But if she is precluded from health care for lack of insurance or limited insurance, does that not create another injustice in society? Those who have access to medical tests will have the choice whether they want to deal with disabled children, whereas those who do not have access will encounter yet another burden - financial, emotional, intellectual, and socio-economic pressures of dealing with a disabled child.

Justice and injustice in health care are much discussed realities in biomedical ethics. What we have discussed so far are only underlying reasons for injustice in health care, such as questions of limited health care access. The Anabaptist/Mennonite physicians' concept of justice seems to reach far beyond questions of the application of justice in everyday practice. These physicians put primary emphasis on the agency of the doctor and his/her embodiment of justice in their daily life.

While trying to embody justice in their personal calling as physicians, they also try to seek out injustice in society. Even though this discussion has concentrated only on the USA, a discussion about justice in health needs to be extended to include different organisational health care systems such as the United Kingdom or Germany. Some of the research on the differences in health care systems has been done already, but there is still room for more research, particularly in the area of global injustice in health care and the involvement of Western distributive injustice to countries of the developing world.⁴⁴³ Within the last decade, Feminist bioethics seems to have uncovered gender-based injustices in global health care distribution.⁴⁴⁴ The problem of justice in health care cannot be adequately dealt with and eradicated if biomedical ethics remains issue-driven, without uncovering the underlying, but driving forces of social injustice that fuel injustices in health care.

Towards an Anabaptist/Mennonite Model for Physician Conduct

In the above discussion we have become aware that servanthood as a model for physician conduct includes several aspects which have been only sparsely emphasised in the recent discussion of biomedical ethics. We saw that a model of servanthood that includes caring and compassion, service and stewardship, is a conscious choice of the agent, the physician. This conscious choice includes several key factors that could have remarkable influence on biomedical ethics and health care. We need to be clear that Anabaptist/Mennonite physicians do not propose to reinvent the basic elements of professional physician conduct, but that they put a high priority on the physician's attitude and character. Such a strong emphasis seems to be based on their understanding that the physician is in a position of power and needs to be more aware of the power imbalance in an attempt to prevent the exploitation of the patient. In that respect, Anabaptist/Mennonite physicians might contribute to contemporary biomedical ethics through a renewed emphasis on the physician's covenant to heal and to promote wholeness.⁴⁴⁵

1. *Communication/Information* is the first key factor that the agent will emphasise in his/her practice in relation to the patient. If, for whatever reasons, the communication

⁴⁴³ For a discussion about health care justice in its relationship to free market economy or social market economy see Beauchamp and Childress, *Four Principles of Bioethics*, Chapter 6. Cf.

⁴⁴⁴ Cf. *Globalizing Feminist Bioethics: Cross-cultural Perspectives* by Rosemarie Tong (et. al.) (Boulder, CO: Westview Books, 2001).

⁴⁴⁵ Cf. Campbell, Courtney, S. "Boundary Crossing: The Ethical Terrain of Professional Life in Hospice Care." In *Caring Well: Religion, Narrative and Ethics in Health Care*, ed. David H. Smith, (Louisville, KY: Westminster John Knox Press, 2000). 201-270.

with the patient is kept to a minimum, one of the crucial stepping stones in the physician-patient interaction breaks down: relationship. Once relationship has broken down, it is not hard to conceptualise that physician and patient enter into a commodity understanding. The patient becomes a commodity for the physician, and vice versa, the physician is seen as a commodity to be exploited by the patient to the point of legal proceedings.

2. *Information and communication take time.* To keep the communicative relationship with the patient open involves a time commitment for both the physician and the patient. It is not difficult to see that neither party involved has much time with the pressures and demands of modern medical practice and biomedical ethics. If it is not a conscious decision for the physician to take time to remain in a good communicative relationship with his/her patient, servanthood has not been achieved. However, one important factor against time and communication is

3. *Cost.* Relaying adequate information to the patient involves money. Consultations are expensive and time is needed to explain to the patient necessary treatment options, should high standards of informed consent be ensured. The issues of time, cost, and information/communication are particularly relevant in issues at the beginning of life with all its related questions in reproductive health and stem cell therapy. Genetic consultations are expensive and complicated to understand for the patient. In questions of informed consent for research subjects, the issues of time and cost and information are even more relevant. Servanthood can become a significant factor in biomedical ethics as it emphasises the importance of relationship with the patient rather than speaking of patients in terms of 'scientific subjects'.

The above mentioned key factors for servanthood sound very similar to key issues of informed consent. However, a focus on stewardship with its focus on communication, time, and cost goes beyond the call of duty of securing informed consent. The physician who practises stewardship will be particularly sensitive to the issue of his/her patients' understanding of key factors before any decisions are taken. Understanding does not only refer to intellectual grasping of medical concepts and its consequences, it also includes the patients' emotional understanding and processing of medical procedures. To that extend, stewardship does include much more investment in the process of understanding of medical procedures before securing informed consent can even be attempted. A good example of this process seems to be found in interview # 9. This physician works with the Amish community, where he

has to do much more groundwork in the medical decision-making process with his patients.

Servanthood as model for physician conduct highlights the need to include three emphases for biomedical ethics:

- Stewardship over limited resources
- Stewardship of interconnections
- Stewardship of limitations.

It will be the work of further research in co-operation with the physicians of this study, to elaborate in detail these three emphases. It will have to be the work of the physicians to actually try to discover ways to embody these three types of stewardship and servanthood. Here we can only briefly sketch ways in which such emphases could influence contemporary biomedical ethics.

Stewardship of limited resources will be acutely aware of issues of distributive justice in health care, particularly in questions of the end of life, in access to health care issues, and in questions of use of resources. Patients should be better informed by their physicians about the issues of limited resources in health care. It just might make a difference if the patient knows that s/he is one of ten people on the list for an organ donation. Such knowledge might give the patient time to think through their priorities in life, and at an advanced age, s/he might be voluntarily taken off the transplant list. Patient autonomy should not only include the right to have any treatment, it should also include the right to refuse treatment.

Stewardship of interconnections will be able to conceptualise holistically the many interconnections between physical health, spiritual health, emotional health and intellectual health. The physician who practises stewardship will be acutely aware of the quest for wholeness that looms in the background of the patient's diagnosis. Stewardship of interconnection will focus on the entire environment of the patient, and sees far beyond the immediate diagnosis that brings him/her to the physician's office. Eliminating suffering and promoting healing will thereby become a means to the end of increased overall wholeness for the patient, not an end in itself.

Moreover, stewardship of interconnections will be able to point out connections between social justice and justice in health care. As the patient in the physician's office is more than the sum of the body parts s/he has, so the patient is also more than just a solitary individual. The patient is part of an intricate social, economic, intellectual and spiritual network that has shaped and moulded him/her. The patient brings this entire network with him/her when s/he comes to the

physician's office for consultation. In the same way, the physician is part of a social and economic network as well, and brings his/her background along. In the physician's office, two worlds meet, the world of the patient and that of the physician. In most cases, the physician-patient relationship resembles a power imbalance, where the patient needs the physician's help. This need of the patient automatically catapults the physician into a power position. The wise physician will be acutely aware of this power imbalance and will do everything in his/her power to make the patient feel comfortable, for if the patient cannot be him/herself, s/he will not be able to tell the story of the disease.

The wise Christian physician will also be aware that the position of power comes with increased responsibility. Those who practise servanthood and stewardship will know that the steward is accountable to the landlord over the things, gifts, people, achievements, etc., that have been entrusted to the steward's care.⁴⁴⁶ In the case of biomedical ethics it is crucially important to be as fully aware as possible of the interconnections of the patient's and of the physician's socio-economic and psycho-spiritual interconnections. Contemporary biomedical ethics seems to focus too much on issues and their effects on the patient and loses sight of the many interconnected reasons for the immense inequalities in health care.

Stewardship of limitations will be aware of the limitations of health care, the limitations of human agency, and the limitations of scientific progress. Limitations here does not denote an end to the search for scientific progress; limitation here is closely connected to the question of justice. Limitation means that not all scientific advancements can be used in every case of medical practice. Advancement in the overall cancer research could still mean that some patients will not be able to receive certain treatments because of complications within their individual cancer cases, i.e. some HIV/AIDS patients respond positively to ATZ and some do not respond at all. Moreover, some HIV/AIDS patients will not know how they would respond to ATZ because they cannot afford this medication and neither does their health insurance cover the cost of the medication. Stewardship of limitations will be closely connected to distributive justice in health care and advocate for their uninsured patients.

Stewardship of limitations will also be very aware of the fact that as humans we are limited by our finitude. This emphasis might help to re-orient our firm belief

⁴⁴⁶ Cf. May, William. *Testing the Medical Covenant*. (Grand Rapids: Eerdmans Publishing Company, 1996).

in scientific progress when we understand that progress might only be achievable for the few who have the financial means to pay for the treatment that such progress offers.

The definition of limitation is crucial in the area of stewardship of limitation. If the physician understands limitation as failure, then limitation might be conceived negatively. Limitation means there is a limit, an end to what the physician can achieve, but it does not mean that the constrained achievement itself is a failure. Stewardship of limitation means that the physician is aware that he/she can only offer limited help to the patient. This means that there might be limited care for a terminal disease but limited care is still care and much more recommendable than no care at all. According to the physicians of this study, limited care is not a failure, but no care would be considered a failure. To that extent, they are pointing out that the US health care system is failing over 50 million citizens who do not have any type of health care.

Stewardship of limitation could also mean that there are limited financial resources, but limited resources are still more than no resources at all. The area of stewardship of limitations is the least explored of all ideas of Anabaptist/Mennonite theology and ethics, but it could become the most fruitful, because this focus could help contemporary biomedical ethics to keep its focus on the end of medicine – which is health and wholeness. William May called for such a focus to be “attentive to the whole patient and assist in keeping and honouring her as a whole in the course of her living and dying”.⁴⁴⁷

In order to make this vision for physician conduct more viable, we need to understand the motivation, or *modus operandi*, for such physician conduct. For the physicians of this study several observations seemed to be important on the outset of the discussion of the motivation for physician conduct. One observation was that not everyone who practises medicine will think that the approach of peace and non-violence will be a viable option for the physician’s practice and concerns in biomedical ethics. The second observation was that peace and non-violence is a Christian’s choice rather than a requirement, therefore, peace and non-violence cannot be made a required principle but might just be a voluntary option. The third observation was that the practice of peace and non-violence is a life-long process. It is a process that is observed, participated in, and embodied over and over, and is thus a conscious choice for ones’ life style.

⁴⁴⁷ May, *Testing the Medical Covenant*. 4.

II. PEACE AND NON-VIOLENT JUSTICE AS *MODUS OPERANDI* FOR PHYSICIAN CONDUCT

In Chapter IV, section II we have established the theological foundation of peace and non-violence.⁴⁴⁸ There the discussion revolved around the concept of εἰρηνη – peace (Gr.) and the Hebrew understanding of שלום – shalom. One important result of these two terms - which denote health, well-being, wholeness, rest, safety, and the absence of war - is reconciliation. The Latin term *reconciliare*, (*re* - back or again, and *conciliare* - bring together), implies that a relationship that has been whole in the past is now separated and needs restoration or re-conciliation. In a biblical-theological sense, Christ is the one who reconciles humanity with the Creator. The disciple of Christ, εἰρηνοποιος – eiraenoios, the peacemaker, is a person who has experienced peace and brings this experience of peace and shalom to other people, and by doing so, enables them to be reconciled with God and fellow humans. Reconciliation has two important directions: the vertical direction indicates that an individual needs to be reconciled with the Creator God. The horizontal direction of reconciliation sets the individual in motion for reconciliation with other people. For Miroslav Volf, reconciliation means that “the inscriptions of hatred must be carefully erased and the threads of violence gently removed”.⁴⁴⁹ For him, reconciliation is the other side of the coin of peace and non-violence. The vertical and horizontal directions of reconciliation are the necessary basis for a two directional peace: the peacemaker has to have experienced his/her own reconciliation with God (vertical reconciliation), before s/he can then be a peacemaker for others (horizontal reconciliation). This process also seems to be the understanding of the physicians in this study when they point to the need to bring peace and non-violence into the discussion in biomedical ethics.

We also need to be clear that the agent decides to make peace and non-violence his/her mode of physician conduct just as servanthood, peace and non-violence are conscious choices. It is therefore vital to understand the connection between choosing servanthood and peace and non-violence in the formation of the individual agent. It is in the question of peace and non-violence where the theological influence of the physicians is most tangible. By growing up in a peace church, and by experiencing the process of observation, participation and

⁴⁴⁸ Chapter IV, p. 115 ff; Cf. Chapter V, p. 138 ff.

⁴⁴⁹ Volf, Miroslav, *Exclusion and Embrace: A Theological Exploration of Identity, Otherness, and Reconciliation*. (Nashville, TN: Abingdon Press, 1996). 111.

embodiment (Chapter IV, section I/B), virtues have been practised and characters formed. This process is the necessary basis for the physician's ability to choose servanthood as a model, and peace and non-violent justice as the mode of operation.

Such a theological influence on the physician is the basis for possibility and responsibility. On one hand, the physician has the option to emphasise peace and non-violence and could thus make a very important contribution to contemporary biomedical ethics. However, a considerable problem arose with this theme of peace and non-violent justice. Even though all the interviewed physicians highly emphasised the need to include this theme in their future considerations about biomedical ethics, they could not provide any real examples from their practice where they actually incorporated this theme already. For exactly this reason of uncertainty about the inclusion of peace and non-violent justice, this theme needs to be at the for-front of Anabaptist/Mennonite theology and ethics that is concerned with biomedical ethics. Peace and non-violent justice could provide a good basis for a renewed reconnecting of the art of healing with the focus of the whole of the patient, not just the cure of the patients' body parts.

Reconnecting the art of healing with the patient as a whole entity needs to be another of the major foci in biomedical ethics. Steering away from biological determinism that focuses all its attention on individual genes and replaceable body parts could be another contributing focus of the peace and non-violent justice attitude that motivates the servant-physician in his/her work. Because not only what we achieve is of great importance but also how we achieve it, adding the emphasis of peace and non-violence to the discussion in contemporary biomedical ethics can become an important stepping stone to achieving greater justice in health care.

Responsibility, on the other hand, connects the Anabaptist/Mennonite physician with his/her heritage of historical involvement in medical missions, mental health services, and geriatric health care in the numerous Mennonite retirement communities around the USA. It is a responsibility also because many of the physicians in this study have done Civilian Public Service (CPS) on grounds of Conscientious Objection instead of serving in the military. Such experience gave them a particular insight into health care systems in America and around the world. Many of the older physicians did their CPS during and after WW II in State Mental Institutions, experiences that have profoundly shaped their understanding of health care.

I think many of the bioethical issues are peace and justice issues. In that way I got deeply involved in the health care reform debate in the Mennonite Church back in 1993-94. As Mennonites we were very involved in that issue in several major conferences on health care ethics and particularly distributive justice in the health care reform. So I think not only my experience as a conscientious objector but also my service in Vietnam, all the way with MCC peace and justice have been major contributing factors.⁴⁵⁰

Practitioners of the historic peace churches of the Radical Reformation should bring issues of peace and non-violence in biomedical ethics to the attention of contemporary biomedical ethics. Due to their personal experience of the devastating effects of war, the interviewed physicians are very well versed in the historical and theological grounding of their ethical approach to medicine (see Chapter II, part IV/C). It seems that this particular Anabaptist/Mennonite focus of peace and non-violence is least tangible in the everyday practice of the physicians, even though there is unanimous agreement about the need to include peace and non-violence. However, practical examples of its actual embodiment are sparse. It seems that it is in the area of peace and non-violent justice that Anabaptist/Mennonite theology can make a substantial contribution to contemporary biomedical ethics, but this is also the area where Anabaptist/Mennonite physicians and ethicists have to do most of their creative work in the future. How these issues could be brought to bear on questions of biomedical ethics will be the attention of this section.

A) Questions of the Beginning of Life

Peace and non-violent justice is at the core of issues in the beginning of life. The issue of termination of pregnancy (TOP) for instance, is at its heart an issue that should be considered from the perspective of peace and non-violence. It is certainly true that it is often a socio-economic issue as well. From the perspective of non-violence, terminating a pregnancy is a violent act, no matter what kind of moral status is given to the foetus. If one considers the biological process of pregnancy with its safety nets of muscle and bone structure in the female pelvis, and the additional security of uterus and cervix to hold the foetus in place, one can only imagine the violent act needed to pry a foetus out of such a safe environment. Violence is done not only to the woman's body, but also to the purposeful interruption of the gestation process. Aside from the question of whether the foetus is a human being or a human-to-be, and aside from the question about the sanctity of life, which are related but different issues, violence against the most vulnerable of society is what Anabaptist

⁴⁵⁰ Pilot Study # 1, p. ii, lines 41-46..

theology severely criticises. It will have to be the responsibility of Anabaptist/Mennonite theologians and ethicists to bring their arguments against violence to bear fully on the issues of termination of pregnancies.

Besides physical violence, we cannot assume that TOPs do not bring emotional violence to the woman as well. Being in the position of having to decide between keeping or not keeping a child brings emotional turmoil to the woman. The physicians of this study have indicated that it is an emotionally stressful time for the woman to decide what to do. They have also pointed out that a caring and compassionate physician who listens without prejudice to the woman's question, could make a difference in the decision. But even if the woman has a pregnancy terminated, the physicians stress that they would welcome the woman back for further discussion about this event.⁴⁵¹ The servant physician who practises peace and non-violence would not want the relationship with the patient to break up over the issue of TOP. Termination of the physician-patient relationship would also mean that the way to reconciliation will be blocked, and that is something the Anabaptist/Mennonite physician will not want to see happen.

On the other hand, when structural socio-economical violence towards the pregnant woman is considered between physician and patient, the decision to continue a pregnancy might be just as violent for the woman as would be terminating it. In the words of one of the physicians, terminating a pregnancy might sometimes be the least of all bad choices a woman has.⁴⁵² The interviews seem to indicate again a rather peculiar position on TOP. The physicians seem to be principally opposed to abortion, but they do not seem to be doctrinaire about their principle. Such attitude toward TOP seems to locate the Anabaptist/Mennonite physician squarely between pro-life and pro-choice camps. In decisive considerations about TOP, structural socio-economic violence seems to be as serious a consideration for the Anabaptist/Mennonite physician as are the issues of violence against the woman's body and emotions.

If peace and non-violent justice is the mode with which the physician operates in his/her practice, reconciliation will be his/her utmost goal. In the question of TOP, reconciliation should include the father of the foetus in this process. It could also include reconciliation between the woman and an unexpected pregnancy.

⁴⁵¹ Email response # 2, p. i; email response # 3, p. i; email response # 4, p. i; pilot study # 1, p. ii, iv; pilot study # 2, p. iv; interview # 2, p. iv-v;

⁴⁵² Pilot Study # 1, p. iv, line 156.

Reconciliation could also mean that the unexpected is welcomed and accepted rather than rejected. The theological notion of hospitality to, and welcoming of, the unexpected has already been discussed by Stanley Hauerwas.⁴⁵³ Being hospitable to an unexpected pregnancy could mean that the woman will keep the baby, or carry it to term and give it up for adoption, rather than abort it. Such a peaceful alternative could be suggested by the physician whose emphasis is a holistic one. For the Anabaptist/Mennonite physician, ethicist, and theologian, there is a vast land of unexplored theological work to be done in the area of peace and non-violent justice. However, for this work to be fruitful, it needs to be approached on an interdisciplinary level to make a significant difference in how we currently view questions of TOP.

If reconciliation is one of the main foci of the physician's embodiment of peace and non-violent justice at the beginning of life, we cannot close our eyes to the even vaster questions of stem cell therapy and pre-implantation diagnosis (PID). Here we not only have to consider the question of violence to the mother, the father, and the foetus, we also encounter the issue of hospitality again. This time, though, it is a question of selective hospitality when healthy foeti are left to complete their gestation process, but such process is terminated for the genetically different foetus. Selective hospitality means the healthy foetus is selected and the genetically different one is discharged. Selective hospitality is closely related to the issue of justice, the question of the value of life, and the question of distribution of resources. PID opens possibilities of selection that we have never before encountered in medicine.⁴⁵⁴ We need to distinguish different levels of selection. One way to select is the preference for a healthy foetus over the genetically unhealthy one. The other type of selection is the gender preference of a child.⁴⁵⁵ Both such practices are unacceptable for Anabaptist/Mennonite physicians who believe that every individual is created equal, and is of equal value in the eyes of the Creator.

⁴⁵³ Hauerwas, *Suffering Presence*. 81 ff.

⁴⁵⁴ Cf. H. Thomas, Murray, "The Genome and Access to Health Care: Two Key Ethical Issues." In *The Human Genome Project and the Future of Health Care* by Thomas H. Murray (et. al.) (Bloomington, IN: Indiana University Press, 1996). 209-223. PID also opens new possibilities of genetic modification. However, stem cell research and gene modification is an entire topic in itself and cannot be treated here.

⁴⁵⁵ Cf. Dorothy, C. Wertz, and John C. Fletcher. "Prenatal Diagnosis and Sex Selection in Nineteen Nations," *Social Science Medicine* 37, no. 11 (1993): 1359-1366. William M. Alexander. "Fatal Daughter Syndrome," in *Globalizing Feminist Bioethics*, by Rosemary Tong, (et. al.) (Boulder, CO: Westview Press, 2000). 179-197.

The positions that I come to, some of it comes from my faith, my foundational belief that the human being is of value and that your financial situation does not declare your value. Your health, a healthy baby is not of more value in the eyes of God than a sick baby. A baby born genetically intact is not of more value to God or to the world; perhaps to society, perhaps to General Motors, if they want a healthy work force. So if they are sponsoring an insurance plan, the insurance plan may prioritise caring for healthy people and discharging the ones who are defective. But that is because big business is behind the insurance plan. That doesn't mean that's morally correct or ethically correct.⁴⁵⁶

Peace and non-violent justice in Anabaptist/Mennonite biomedical ethics will understand the connections between medical practice and questions of misguided utility, as the interview above states. Reconciling the different forces of patient care on one hand, and socio-economic utility on the other hand, has to be the highest priority for an Anabaptist/Mennonite biomedical ethics. The practical embodiment of such an ethic is not the work of this dissertation however, and such contributions have to be worked out by every Anabaptist/Mennonite involved in health care work. The contribution of this dissertation is to show that Anabaptist/Mennonite theology offers possibilities for a more holistic approach to biomedical ethics.

B) Questions at the End of Life

In questions at the end of life we can see similar processes at work. The servant physician who embodies peace and non-violent justice as his/her modus of operandi will be very concerned about reconciliation, particularly in questions at the end of life. We will again find a strong emphasis on maintaining relationship with his/her patients, but the focus will have shifted from maintaining life or enhancing life (see section A above) to releasing life. Releasing life in this context means finding the right place and right time when all concerned parties (the directly affected patient, the familial and other close relationships of the patient, the attending physician and nursing staff, the minister/priest/rabbi/imam) agree to release this life and relinquish it to the natural process of death. A renewed emphasis on reconciliation and releasing life could have several important results for the whole of health care.

With a focus on justice in health care, releasing life is directly related to questions of limited resources. If the physician and the patient have a reconciling relationship, and if the relationships of the patient and his/her closest relationships are reconciled, then life does not have to be clung on to until the very last resource

⁴⁵⁶ Interview # 3, p. v, lines 212-220.

has been exhausted. Such an approach could influence the use of sparse resources in health care, and is directly linked with another underlying issue, the question of the quality of life rather than the quantity of life. The quality/quantity discussion was best answered by the physicians with extensive work experience in the Amish community. In this community it seems that the emphasis is to 'let nature take its course' rather than to apply every medical intervention to save someone's life. Letting nature take its course seems to be combined with an understanding of the temporality of life. Once a good quality life has been lived, one can let go of it. Whatever decision will be made, it is the responsibility of the physician to keep the reconciling relationship alive and to learn what this particular community has to offer.

Hardest thing for me is to convince them, but they think I have something [to cure]. I need to put them on a respirator to get them from here to there [hospital], then they see all the tubes and everything else, they think the person will make it, as far as they're concerned. But they don't know all the statistics, I am trying to convince them that this is just temporary. Because if it is just temporary, they would rather stop everything. That's the same with new-borns, prematures that I think we just need this help to get from here to there. But then they see the baby has a tube in every orifice, they think the baby's suffering even though it may not be. And then you talk to them about electrolytes and acid based, and we [the medical staff] know we get them through, but they don't understand that. "The baby looks sick, it's going to die, so therefore stop everything." It's still hard to convince them.

On the other hand once I'm convinced [the patient will die], it's the same thing. I back off a lot quicker. I don't push, unless I'm pretty sure the percentages are pretty high that we can still help. But once, to give a chemotherapy to make somebody live 6- 8 months, and lose all the hair and all the side effects, if you give everything and they'd live 8 month, or nothing and they live 2 month, they'd go for the 2 month.⁴⁵⁷

The physician who has a reconciling relationship with his/her patients will be wise to know when it is time to suggest relinquishing and releasing life. Such a physician will then also be able to help prepare for the dying process rather than elevate the hopes for cure and thereby increase the level of medical futility. This physician quoted above has over 35 years experience with the Amish community and seems to have realised just this process. Releasing life is not the physician's first impulse, it is rather to save and to cure. However, particularly in the area of end of life issues, we need another emphasis as a counter balance to the unflagging belief in

⁴⁵⁷ Interview # 9, p. iii, lines 107-122.

unlimited medical progress. On several accounts, such a counter emphasis is not utopian.

First of all, there is the question of limited resources which is a struggle in almost all countries. Most of a person's financial resources are spent at the end of life, or in the last several years of life. Such expenditure has to be revisited without resorting to "rational suicide," as Harry Moody calls it.⁴⁵⁸ If there is a reconciling relationship between physician and patient, such resource problems might be counterbalanced with a wise choice of when the adequate time comes to release life. Releasing life should not be mistaken for purposefully ending life.

The euthanasia debate revolves as much around the issues of waste of resources in light of the futility of treatment, as it revolves around the question of control over suffering. In addition, euthanasia is often also the question of an acceptable death with respect to the dignity of the patient. And here Hauerwas is right to stress that it is morally unacceptable to end a life in an attempt to relieve suffering. Relief of suffering and respect for the dignity of the person go hand in hand with the question of adequate patient care and pain management at the end of life. However, for a Christian it is also unacceptable "to cling to life at all costs," for such practice would show a mistaken emphasis on life as an end in itself.⁴⁵⁹ In a similar vein, William May calls euthanasia "control that we demand, not a breakthrough to existence and meaning beyond the urgency of control".⁴⁶⁰ Releasing of life will take account of adequate pain management to relieve suffering, but it will not push for an end of life by euthanasia. Releasing life and ending life on purpose are two different aspects of end of life care which are decided by the quality of the reconciling relationship between physician and patient.

Secondly, we need to revisit the question of the meaning and quality of life. Quality of life is not equal to quantity of years of life. The quality of life question has to be asked long before the patient is admitted to a hospital ward or a rest home. Quality of life and meaning of life need to be the considered focus during the entire span of one's existence; it is futile for them to become the focus of discussion solely at the end of life. In this question, theologians, philosophers, ethicists and many other specialists of the life sciences need to join forces to come to sustainable conclusions.

⁴⁵⁸ Moody, *Ethics in an Ageing Society*, 74. See there especially the entire Chapter 4: "Rational Suicide on Grounds of Old Age?" 71-88.

⁴⁵⁹ Hauerwas, *Suffering Presence*. 36.

⁴⁶⁰ May, *Testing the Medical Covenant*. 47.

And it is here that Anabaptist/Mennonite theology can make a vital contribution to the current discussion.

Thirdly, discussions surrounding the “good death” need to be firmly rooted in reconciling relationships between physician and patient and family/friends. Much of the euthanasia discussion seems to be driven by the fear of pain and loss of autonomy that comes with terminal illness or with sudden accidents. A good or meaningful death can only follow a meaningful life. If, as Anabaptist/Mennonites and many other Christian denominations believe, we are householders/stewards of God’s creation, that should include stewardship of our physical existence as well. Bonting comments that “we are rent masters over our own lives as well as over everything else that God has created”.⁴⁶¹ If we are the stewards, we are not the owner, and if we are not the owner, do we have the right to make the final decision when to end our life? Bonting realises that euthanasia has much to do with the autonomy of the patient and beneficence of the physician. However, euthanasia also has much to do with pain management.

Well I think intention is a really important issue, what is intended to and what isn’t. When one terminates life or when one removes the feeding tube and says “this has gone on long enough,” and when one chooses the moment of death are two different things. I’m not sure I’m keeping faith with the patient when he dies, and I don’t want the patient or the family to think that I would ever cause a death. They will also know that I will not needlessly prolong suffering, and I leave that to God and I get out of the way. And I believe we play God just as much when we needlessly keep adding more and more and more intervention. Playing God is not part of my duty, that’s nonsense. And my getting out of the way and having a natural process is the humane and the good thing to do.⁴⁶²

The servant physician who embodies peace and non-violent justice will be in an appropriate, reconciling relationship with his/her patient and know when it is time to release or relinquish life. The particular contribution that Anabaptist/Mennonite theology brings to questions of the end of life is to see the patient in his/her entire life connections. This theology contributes to a better understanding of quality of life and death, of a holistic approach to medical care at the end of life, and it contributes to a better understanding of compassionate care for all who are involved in the death and dying process.

⁴⁶¹ Bonting, *Mens, chaos, verzoening*. 143.

⁴⁶² Pilot study # 1, p. iii, lines 110-118

C) Questions of Justice in Health Care

Justice in health care is a contentious term because it has multi-faceted origins and it is an approach with different interpretations of justice. Justice in health care is often equated with questions of distribution, access, use of limited resources, agency, and decision-making. The problem we are facing in the question of justice in health is that the definition of justice is very closely related to the definitions of the market. The US, for instance, operates on a free market economy with all its related systems and interpretations of such a free market economy. The brave, the free, the independent, and the strongest will get the biggest share in such an economic system. The social net in such an economic system is not necessarily based on the intrinsic equality of all people, but is based on the buying power of such a social safety net. Those who are strong can buy themselves a strong social safety net, i. e. expensive, all-inclusive coverage in health care, whereas those who are economically not so strong have a social safety net that is not as strong. Health care premiums can be paid, but they do not include dental care, eye care, prescription medication etc. The weakest of such a society will not be able to afford a social safety net at all. However, the budget of this country must allocate resources in the form of welfare for those citizens who cannot supply their own social safety net.

Societies that are based on a social market system such as Germany, France, or the UK, try to supply a basic social safety net for all citizens at a decent minimum level in the form of universal health care. If, through social or natural lottery as Rawls call it, one can afford anything extra, one can buy additional social and medical safety, in the form of additional insurance, for instance.⁴⁶³ However small and fragile, the social safety net in a social market economy is still stronger and more inclusive than its equivalent in a free market economy.

Even though this is an extraordinarily simplistic picture of health care in a free market vs. in a social market, it nonetheless serves to make the point: discussions of justice in health care can never be divorced from discussions of economic systems with their inevitable social and economic inequalities. As interesting as it would be to follow this thought, this dissertation is not the place to do it; and it has been done elsewhere.⁴⁶⁴ However, the discussion of justice in health

⁴⁶³ Quoted in Beauchamp and Childress' *Four Principles of Bioethics*. 343.

⁴⁶⁴ Cf. "Globalization, Gender, and Research" by Florence Luna. In *Globalizing Feminist Bioethics* by Rosemarie Tong (et. al.) (Boulder, CO: Westview Books, 2000). 254-265.

care is exactly the point where the Anabaptist/Mennonite physician can, and should, contribute extensively.

The Anabaptist/Mennonite contribution to justice in health care should not only be made on account of the historical precedence of involvement in peace and justice concerns of the Mennonite Church USA, but also because of the physicians' own experience with the vast discrepancy within the health care system of the US. Embodied servanthood as a model for physicians, combined with the reconciling action of peace and non-violence, can powerfully question injustice in health care.

The reason that the governments and the insurance companies and the big businesses, what motivates them to decide who to offer care to and when to cut it off, is not necessarily what motivates the person who believes that we are all born equally valuable to God. And the suffering of a sick child is as wrong as the suffering of the CEO of General Motors. If he hurts and a baby with Down's syndrome hurts, that hurt is just as bad and it's just as important. It is not more important to relieve the pain [of] a wealthy man in a three piece suit than it is to relieve the pain of a suffering child. So that kind of conviction will help me when I'm discussing or fighting for when I see a policy in place.

That is what I firmly believe. But that isn't always the way the policy makers and decision makers [see it]. They talk about whether it's cost effective to do mammograms to women in their 40s. Is it cost effective, ok? You can let that question go by, but then, wow, how did you decide what is the value of a life of a woman in her 40s? How did you calculate that? To decide that they would buy so many dollars worth of mammograms to save so many years of life, how did you assign a value to that life? Is it economic value? How do you weigh? Some of those questions, if you push too hard you may not like to know who decided how valuable the life of a woman is!⁴⁶⁵

This physician has practised internal medicine in her own private office, and offered numerous free or reduced consultations. Her office was financially viable until she sold it to a Community Hospital, who then forbade her to keep providing free health care. Since she sold her office, she has severely criticised the hospital's policy of cancelling all free treatment, and has, as a consequence, been threatened with termination of employment. In the interview she insisted that it was her Christian duty to provide free health care whenever possible to many of her uninsured and underinsured patients. Her powerful example of what the Anabaptist/Mennonite physician can contribute to questions of justice in health care can be summarised in three main points.

First there is the issue of *advocacy*. The physician-patient relationship is still among the most primary relationships in health care and it is from this relationship

⁴⁶⁵ Interview # 3, p. v-vi, lines 226-244.

that advocacy for one's patient arises.⁴⁶⁶ We certainly have to be clear that not all physicians interpret advocacy in the same way, and even among Anabaptist/Mennonite physicians there seem to be discrepancies about the exact meaning of advocacy. Nonetheless, all interviewed physicians are clear about the fact that 50 million uninsured US citizens is a disgrace for one of the richest nations of this world. Advocacy can certainly have many faces, but for the physician who embodies servanthood and strives for reconciled relationships in health care, advocacy has priority on two counts. On one hand it is the humane, decent, and professionally required action on behalf of one's patient. On the other hand, though, Anabaptist/Mennonite physicians deduce advocacy for the poor and disadvantaged from Jesus' command to take care of those who cannot take care of themselves, the poor, the widow, the orphan, the stranger. Interestingly enough, this command is not only found in Christian scriptures but has its roots in the Torah as well as in the Koran.⁴⁶⁷

Secondly, as we have seen in the interview excerpt, advocacy inevitably leads to *involvement*. As does advocacy, involvement can have many expressions. Whatever shape involvement takes for a particular patient, or patient group, involvement will never be without its costs. However, the servant physician cannot be uninvolved and only concerned with his/her own good. Such an attitude would be contrary to what the disciple/peacemaker/servant is called to do. He/she is to seek the best for those who are entrusted to him/her, and has to seek the advancement of the cause of his/her master (see Chapter IV, Section II/B). If shalom for those entrusted to us is the goal of the servant-peacemaker, then such a physician has to get involved. We have seen throughout the excerpts that Anabaptist/Mennonite physicians have been involved in many areas of health care in the past, but there has to be more creative involvement on behalf of the patients for more just health care. The particular shape of such future involvement in biomedical ethics and the shaping of justice in health care cannot be the task of this dissertation but needs to be determined by the physicians themselves.

Advocacy for the patient, and involvement against unjust health care calls thirdly for *creative changes*. Creative changes in health care will not happen if the physician does not see the need for either advocacy or involvement. Complacency

⁴⁶⁶ Pellegrino, Edmund D. "Philosophy of Medicine: Should it be Teleologically or Sociologically Constructed?" in *Kennedy Institute of Ethics Journal*, Vol. 22:2 (2001) 169-180.

⁴⁶⁷ Ali, Abdullah, Yussuf. *The Holy Qur'an*. (Leicester: The Islamic Foundation, 1975). "Sura ix, 10-13; Sura ii, 177-220.

and status quo thinking are enemies of creative changes. Anabaptist/Mennonite physicians cannot be complacent on account of their historical and theological heritage. Historically, Anabaptist/Mennonites have always responded to need in the world in the form of relief work, medical help, or educational opportunities through MCC and many other relief organisations as described in Chapter IV, section I. Such a response cannot be limited to work abroad, but needs to include creative involvement in changes in the health care system in their own country as well. As a result of the historical development, the theological heritage of Anabaptist/Mennonites seems to be more adaptive to change without losing its core message; as one of the interview partners put it:

I think Anabaptists do the theology on the road. I think they have a theology that is transportable, that fits into different settings. Like the people I grew up with, their theology only fits in suburban, white middle class America, it can't go to Zimbabwe, it doesn't fit there... It's the gospel of white middle class northern USA. But the Mennonites really have a theology that isn't just for the Mennonites in Eastern Pennsylvania. It's a theology of how God looks at the human but it fits in the African human, and the Asian human, and the European, and the South American, and Central American. It's much more real, and it's much more able to be taken right from the scripture to where I am here.⁴⁶⁸

As this physician confirms, the adaptability of Anabaptist/Mennonite theology is one of its greatest assets. She grew up with a different, more fundamentalist theological approach, but has 'married' into Mennonite theology. Her assessment is particularly poignant, as she is also the medical director of a hospital in Honduras, where she is actively involved in medical missions. Just as advocacy and involvement will cost the physician, so creative changes come at a cost. It seems that Anabaptist/Mennonite theology and ethics have prepared its physicians particularly well to embody the characteristics of servanthood and peace and non-violence in their respective choices of medical expertise. What will be needed in the future is that Anabaptist/Mennonite theology of embodiment will become a mature conversation partner with contemporary biomedical ethics.

Towards Peace and Non-violent Justice for Physician Conduct

We have seen that the mode of peace and non-violent justice for the Anabaptist/Mennonite physician is significantly influenced by the Old and New Testament understanding of peace. Shalom and eirene convey a holistic understanding of wellbeing, which includes physical, emotional, political, and

⁴⁶⁸ Interview # 3, p. iii, lines 120-128.

economic health. The disciple of Christ/peacemaker will work towards reconciled relationships with his patients. At the beginning of life, such a reconciling attitude emphasises the need

- To maintain relationships with the patient;
- To maintain life.

At the end of life, however, different needs arise which need to be addressed differently. Besides a sustained focus on maintaining the relationship with the patient and the family as long as possible, reconciliation here also emphasises the need

- To appropriately release life.

These are practical contributions that Anabaptist/Mennonite physicians can bring to the discussion with contemporary biomedical ethics. In such an approach the patient is not only seen as an individual but as part of a social system, a system that needs to be adequately understood and addressed by the attending physician. Such an approach also counteracts an increasing tendency in biomedical ethics to see the patient as a means to an end, e.g. a research subject, a scientific object, another insurance card-carrying client. Reconciling relationships also means to uncover socio-economically based health care injustices that prevent patients from living out their full potential as human beings.

In questions of justice in health care, the specific Anabaptist/Mennonite contributions should revolve around three different, but interrelated issues. Such issues are again based on the physician's motivation to embody reconciled relationships in his/her medical practice.

- Advocacy
- Involvement
- Creative Change

If these elements are embodied by the reconciling physician, important and incredible changes could happen. Anabaptist/Mennonites have the potential to be very creative when it comes to effecting change. One physician of this study has already begun to operate a clinic for uninsured Americans. He is the only one of the interview partners who is so obviously creative. He clearly stated that his work is neither cheap nor easy, but that his pacifist Mennonite background and theological conviction has prompted him to effect such change in his area.⁴⁶⁹

He is just one example of many physicians who could effect similar change in their own surroundings, or even in the American health care system. The most vital

⁴⁶⁹ Interview # 7.

contribution of these physicians would be to talk about creative ways to advocate and to be involved, so that other physicians can see, and be encouraged to effect change themselves.

It may be quite clear now that such efforts at change cannot be done by the physicians on their own. For this reason we now need to turn to the third major aspect of this theological approach, to community as the sustaining and sending forum for the physician who practises servanthood and peace and non-violent justice.

III. COMMUNITY AS A SUSTAINING AND SENDING *FORUM* FOR PHYSICIAN AND PATIENT

We have seen in Chapter IV, section I, that the community of believers and the individual are closely intertwined and inter-related. The particular Anabaptist understanding of community hermeneutics, or the community of believers, is a result of historical and social experiences of this group. We have seen that formation of character and identity also happens in close relationship with this community. The physicians have provided us with an idea about how such character formation occurred. It is safe to say that in this theological approach a process of participant observation happens. This virtue and character formation is then verified through the individual's embodiment of a particular ethics (Chapter IV, section I/B).

In Chapter V we have then probed ideas and thoughts about this community of believers more deeply and compared it to the theological scholarship of John Howard Yoder. In section I part C of this chapter, we found that Yoder not only defines what and who this community of believers is, he also describes various tasks of the community of believers. Yoder's term for the world-wide community of believers is church with a small 'c'. This church includes everyone who believes in, and follows Christ in every day practice, everyone who is baptised and who receives the Lord's Supper as a sign of his resurrected body. By using church with a small 'c', Yoder distinguishes the active community of believers from those members of the Church who are only nominally part of a religious denomination. Yoder's interpretation of church can be found on a local level, and on a regional and national level, but most importantly, it is found on an international level. Such a church transcends credal, national, gender, intellectual, and socio-economic boundaries, and is ecumenical in the truest sense of the word.

We also found that there are various tasks of the community of believers. According to Yoder there is the hermeneutical task which helps the individual within

community to make sense of the word of God and of the world in which we live. Then there is the formative task which helps to form and shape the virtuous character of the individual and the community. Then there is the prophetic task, which, according to Yoder is where the church becomes pulpit by proclaiming the word of God in word and action; and the church also becomes a paradigm according to which the surrounding world can see glimpses of the saving grace and actions of God (Chapter V, section C 1-3).

We will now endeavour to show how the community of believers can be a sustaining and sending forum for the physician as well as for the patient. This section in itself could be the basis for an entire dissertation, but naturally has to be brief and concise.

A) A *Forum* for the Physician

A Sustaining Forum

In questions at the beginning of life, the community needs to become first of all a safe forum for the physician where s/he can express questions related to beginning of life issues. It might often be assumed that physicians have no need to discuss and process ethical or moral questions concerning their professions with their faith community. It seems often forgotten that physicians are human beings as well who have to deal with almost irresolvable questions and quandaries. Even though the physician has his/her professional organisations and colleagues to discuss such issues, he/she also needs to be able to bring questions about the beginning of life to his/her primary faith community. The faith community in turn should display openness and/or interest in discussing, or at least listening to, the problems the physician faces. However, this quest brings us to a different, but somewhat related problem: ministers need to be educated more comprehensively in matters of biomedical ethics so that they can more effectively serve medical personnel.

The physicians in the study have clearly pointed out that the ministers/churches have here a responsibility that is not taken seriously enough. One physician, who responded to the initial email questionnaire, does not seem to have adequate help from his church community to wrestle theologically with questions of medicine, in this case, the question of withholding or withdrawing treatment.

I think your question on whether other Anabaptists would agree on these questions is a good one. There is a tremendous dearth of teaching in the Church on these questions, because most theologians never have to grapple with the reality of these decisions. I have made many decisions to withdraw

treatments like the second case, and I have made them in the absence of any direction from any other human being. Prayer alone has been my guide.⁴⁷⁰

It seems that many ministers are so overwhelmed by the daily business of ministering that they do not have adequate time to educate themselves on questions of biomedical ethics, hence, the ministers do feel inappropriately prepared to discuss these issues with the congregation or with the physician in the church. At root, this is a theological and educational problem. Theologically it is a problem because there is much ambiguity about issues of biomedicine in the churches. The educational problem is that most ministers leave seminary without having been adequately prepared to minister to parishioners on biomedical questions. This is one major problem for our point here, but it is an issue that needs to be addressed on a larger scale in a different setting from this dissertation. However, the church that is fully prepared to minister to all its members cannot neglect its responsibility to those who work in the medical professions. Churches have to find ways to become a sustainable forum for physicians, lest they lose their physician members to places that do provide such emotional, intellectual, and spiritual support.

A Sending Forum

Secondly, the community of believers needs to be more clearly and pro-actively a sending forum for the physicians. On one hand, the church has to become the place where a theology of vocation is developed. A vocation is not just a job, it is a career chosen as a result of a strong sense of calling. The epistemological root for the term 'vocation' is in the Latin *vocare*, meaning to call. If the physician sees him/herself called to the healing profession, the church should support such a choice with a theologically grounded understanding about the meaning of such a calling. Furthermore, much theological teaching is still geared towards 'saving souls' without understanding the intricate connection between our physical and spiritual well-being.

The whole belief in shalom, in peace, I think needs to somehow play in how we practice. It's not just about not going to war, it's helping people to be whole, it is more of a justice, as Anabaptist/Mennonites it's more of a just salvation. It's helping people to be the most they can be in the condition they're in, physically, mentally, emotionally and spiritually, about ministering to the whole person. And I think in some ways our view of salvation is a bit different than other groups, in that it does involve that. That's why I think the Mennonite churches had MCC, not just a mission agency that goes out and saves souls.⁴⁷¹

⁴⁷⁰ Email Response # 3, p. ii, lines 73-78.

⁴⁷¹ Pilot study interview # 2, p. v, lines 176-183.

Even though the Mennonite Church USA does put much emphasis on discovering connections between body and soul, physicians are normally not 'sent out' to their vocations in the same way as ministers or missionaries. If we want to understand the connection between body and soul and spirit, everyone who works in any of these areas needs to join forces with a more urgent sense of ministry in this world.

On the other hand, a similar sending effort could be put in place for young persons who think of going into the medical professions. The community of believers which really understands itself as a sending forum will send its young people into a variety of chosen professions with a strong sense of calling. We have seen in Chapter IV that character and identity seem to be formed and shaped within the participation-observation-embodiment pattern. When this pattern is connected with a theologically sound understanding of *vocare*, the young physician-in-training will understand him/herself as a person sent and supported by his/her faith community. Such a sending process for the young physician-in-training could have a tremendous impact not only on the individual, but also on the community which serves him/her. A reciprocal understanding of responsibility would grow where both parties realised the need for mutual support.

In actual questions of biomedical ethics the community could act as a sounding board for physicians who need to voice their questions and insecurities about treatment decisions. In an appropriate setting of confidentiality, medical quandaries could be discussed theologically. This can be a minister-physician meeting only, but it could also include other health professionals. It should be clear that the final decision about treatment lies with the patient in the security of the physician-patient relationship. However, providing the physician with a safe place to voice his/her questions should be the primary focus of the churches' ministry to her health professionals.

B) Community as Sustaining and Sending *Forum* for the Patient

The community can be a sustaining forum for the patient in many questions of biomedical ethics. There is first the possibility of help in the decision-making process over ethical questions in medicine. Then there is the sustaining, long-term support for the patient and his/her family in a medical crisis. And thirdly, the community might be needed in a long-term support role after the immediate medical crisis is over.

Community as Forum for Decision-making

We have seen in Chapter IV and V that the Anabaptist/Mennonite sense of community identification is very strong. Decision making in such churches can be a long and arduous process, but it can also be a very rewarding process. Members of the community are encouraged to share their opinions, and decisions are made by the highest level of consensus. A few safeguarding remarks should be set out for discussion in questions of biomedical ethics.

Discussing questions of ethics in biomedicine in the church is first and foremost a voluntary process which should never become a requirement. However, it should be on the top of the church's agenda to offer the possibility of discussion to her members. In addition, not the entire church community needs to take part. The forum could rather be similarly organised to ethics boards or ethics panels of hospitals. Church members with professional experience such as physicians, nurses, social workers, counsellors, lawyers, and ministers could 'donate' time to such a panel in which specific cases are discussed. Moreover, such a discussion panel should be clear about the confines of confidentiality about medical information. Such confidentiality would not preclude informing the larger congregation about decisions, but all parties of the ethics panel would agree about the type of information that would be shared. When a member of the congregation has a major ethics decision to make, the panel can be called and it can provide informational input and also support the process of decision-making of the individual(s). The minister should liaise between the congregation and the panel, since s/he is usually the first to know about impending crises.

In questions at the beginning of life, the panel could, for instance, be asked to assist an infertile couple with the decision whether to utilise IVF. The panel would provide technical information about cost and length of treatment, probability of success of treatment, physical and emotional stress points during the treatment, and a host of other issues connected with fertility treatment. In addition, the panel would be able to point to various controversial decisions that come in light of such treatment. Here the discussion could revolve around the decision to terminate some of the foeti in favour of one or two healthy ones. How would the couple be able to deal with such a decision? Likewise, the panel could point out that there would be an option for pre-implantation diagnosis with the possible news of a genetic disability of the foetus. If applicable, there could be a helpful discussion about the use of donor gametes for the fertility treatment. What would the couple think about this option?

Another different but related discussion could revolve around the possibility of adoption rather than having biological children. Counsellor, social worker and minister could be helpful in finding the right balance in a discussion about IVF vs. adoption. Psychological issues in connection with parenthood could be uncovered in the process which might need to be addressed on a longer term basis. These are only a few issues with which an ethics panel in the church could assist a couple in its quest for children.

Similarly, at the end of life, questions about withdrawing or withholding treatment can be discussed with the panel. Legal implications can come to the fore in end of life issues, particularly in questions of long term care of an elderly person in the family or the church family. Financial issues connected with long-term or hospice care can be discussed here. Emotional burden and endurance of family members are part of the discussion here; included in this discussion should be the contributions of the larger church community to relief for immediate carers. In questions of long-term care of an Alzheimer patient, grief counselling might be called for at a very early stage, when the beloved family member does not seem to be him/herself anymore, when a loss of personality is clearly apparent. At this stage questions of the meaning and quality of life could also be part of the discussion, in which the minister should assist.

Community as Forum for Intervention

In questions of justice in health care, the ethics panel might be challenged most. If, for instance, a member of the congregation does not have adequate health care but has an accident and needs serious treatment, what is the responsibility of the congregation? If the church has a responsibility, how is she prepared to deal with such a case? The following interview excerpt shall serve as a case in point:

This guy came in, he had an accident, hit his head and was on blood thinners, and I tried to convince him he should get this CAT scan, to make sure he was not bleeding in there. But he said he felt better, 'I don't have insurance, I didn't wanna do it', put on his shirt, said he couldn't afford it. But I thought that was a pretty good chance he was bleeding. Sure enough, two hours later he passed out, went to the hospital and sure enough he was bleeding, the next day he died. So it's tough, I don't know, should I have forced him, but then you think of his autonomy, you educate people give them their autonomy to make the decisions. But I really thought it was in his best interest to have it done, but it was the first time I'd met the guy, he was very insistent that he didn't have money, no insurance. And then on the other hand, his employer is a pastor of a fundamentalist church and doesn't give him health insurance. So

I think now should I be going to this guy and bawl him out? I haven't gone yet, I thought about it. There are a lot of ethical issues in that one.⁴⁷²

There are surely a lot of ethical issues in this case, and the physician was still rather upset about this case at the time of the interview. He was asking the question of justice in health care and access to health care. The ethics panel of the church could be aware of those members who do not have health insurance or are only inadequately insured. Together with the commission for finances in the congregation, they could work out a plan to have resources available for critical cases such as the one mentioned above. It seems that the man in this case was opposed to going to the hospital because he did not have health insurance. We cannot speculate about his chances of survival here, because we lack adequate information about the accident and his injuries. However, what we can speculate on is the fact that if he had health insurance coverage, then he would have been in the hospital by the time he lost consciousness.

An ethics panel in the congregation would also have the means to establish funds for members who needed financial assistance for prescription medication that was not covered by their insurance plan, for instance. Or the church could perhaps establish a parish nursing program to offer basic health screenings, health education classes, and disease prevention education. These are little things a congregation can do without spending the entire budget on one invasive intervention. A parish nurse, in conjunction with the minister(s), could show awareness of the many injustices in health care that happen in each congregation, and, in conjunction with a congregationally-based ethics panel, crisis intervention in health questions could happen quickly and effectively at minimal cost.

The above mentioned ideas about the churches' involvement as a sustaining forum for the patient are only a few of the ideas which have emerged from the interviews and from this dissertation. These ideas were mainly prompted by the physicians' persistent questioning of the relationship between the individual good and the community good.

I'm not the autonomous physician individual, I'm the member of a living community, supposedly. So what does this mean, what does this mean to all of us as physicians, do we hold our own personal independence in high regard, or do we live as members of the community? That community element is a recurring theme that I am more and more in touch with, and

⁴⁷² Interview # 8, p. iii=iv, lines 127-142.

community can also have a dimension of the MMA, [we] can be a community of people who challenge each other.⁴⁷³

...[T]he community part of it, to see not only the individual in front of you but how they relate to a larger community...this real idea of community, sharing resources, nobody being better than anybody else, that is not that much different than some aspect of Socialism or the early church Acts, Sermon on the Mount, that type of theology, you know, and some of the revolutionary Catholics too.⁴⁷⁴

...Social ethics and implications for managing public health and economics. When does the “social good” take precedence over the “individual good”?⁴⁷⁵

The community which is a sustaining community will be creative in working with these ethical questions in medicine. It will become unmistakeably clear to the leadership of such a community that the physical, emotional, spiritual, and intellectual health of the community will only be as good as the health of its weakest member. Taking adequate care of those weakest members would not only serve the internal dynamic of the community, it would also set a precedent for those who are quite uncertain about the community of believers. In the words of Yoder, by taking care of the members’ health care questions, the church would become a “paradigmatic social ethics,” revealing to the world what the Kingdom of God is all about: servanthood instead of domination, enemy love instead of war, reconciliation instead of exploitation.⁴⁷⁶

C) Community as Basis for a holistic Theology of Embodiment

The community that emphasises servanthood as a model for conduct not only for physicians, but for all its members, will have the potential ability to make a dramatic impact. If this model of servanthood is combined with the mode of peace and non-violence, the community will have a powerful tool at its disposal to make a dramatic impact in many areas of society. In biomedical ethics, which is the main concern of this dissertation, the community itself will become a part of embodied theology in many practical aspects, as we have tried to describe earlier in this chapter.

Holistic theology of embodiment will mean that the church understands its mission to be larger than just saving souls, as we have been reminded by many of the interview partners. Holistic theology will then include physical aspects of a person’s

⁴⁷³ Interview # 7, p. vi, lines 240-246.

⁴⁷⁴ Interview # 4, p. viii, lines 3327-328, 352-356.

⁴⁷⁵ Interview # 1, p. iv, lines 140-141.

⁴⁷⁶ Yoder, J. H. *For the Nations*, 37-50.

life as well as emotional and spiritual aspects. Such theology will also be keenly aware of the social and economic influences on a person's overall well-being. Holistic theology cannot pretend that human beings live in a unilateral society where cause and effect can be easily determined. The multi-faceted interconnections need to be understood and dealt with simultaneously if holistic theology wants to be viable.

Holistic theology of *Embodiment* understands that it is not enough to be theoretically and academically engaged in the struggle for wholeness. Such a theology will not be satisfied by simply knowing the relationship between ill health and inadequate nutrition, and between poor housing and minimal wages. Holistic theology of embodiment will seek action to improve individual components of such a vicious cycle. By embodying such a holistic theology, this community of believers will not only follow Christ's commandment to seek out injustice, but this community will also have a chance to act as agents of reconciliation between humans and between humans and the Creator.

The community which is the basis of *holistic theology of embodiment* will know that it is only a community by the sum total of, and engagement with each individual member/agent. Therefore the success of the mission of this community depends on the adequate preparation of each agent, and the community will take great care to incorporate the contributions of each agent as fully as possible. Each agent in his/her chosen vocation will embody holistic theology in everyday life, thereby trying to be an agent of reconciliation in every situation.

Conclusion to the Chapter

In this chapter we have set out to answer the question of what difference servanthood, peace and non-violent justice, and community would make in actual questions of biomedical ethics. Since those were the dominant themes that have emerged from the empirical study, it would be crucial to find particular ways to apply those themes to biomedical ethics if the objective of this dissertation were to be met. We set out to show that Anabaptist/Mennonite theology and ethics could indeed contribute significantly to the discussion in contemporary biomedical ethics.

In section I we found that if servanthood is practised as a model of physician conduct, several issues emerge that can be of importance to biomedical ethics. Besides emphasising the need for the physician to make a considerable investment of time to inform and communicate with his/her patients, we also found three significant foci of servanthood - foci that might not have been at the front and centre

of discussions in biomedical ethics as of late. We found that the physician who embodies servanthood can accept the limitations of his/her art of medicine, not only its successes. Stewardship of limited resources, stewardship of interconnections, and stewardship of limitations do not serve as measures of failure for the physicians, they are much rather communication markers between the physician and his/her patients (section I/A-C). When servanthood is the model for the physician, the relationship with the patient is such that limitations in medicine can be, and should be, honestly acknowledged and discussed. Only if such honesty is practised can the patient come to a fully informed decision with the best possible support of the physician.

Section II discussed the possibility of peace and non-violent justice as a mode in which our servant-physician works. Here we found that *reconciliation* is the result of practising peace and non-violence and becomes the focal point in the physician-patient relationship. If reconciliation is the goal for the physician in the relationship with the patient, then he/she will have the *conservation of life* as the main goal in questions of the beginning of life. At the end of life, the goal becomes the *release of life* without unnecessary prolongation of suffering or wasting of resources. In questions of health care justice we find three ways in which the physician can interact with his/her patient. *Advocacy*, *involvement*, and *creative changes* are the foci of the Anabaptist/Mennonite physicians in questions of peace and non-violent justice in health care ethics.

Section III of this chapter has become the basis on which much of the Anabaptist/Mennonite embodiment in biomedical ethics rests. Community is the sustaining and sending forum for the physician as well as for the patient. Community is the place where individual agents are formed and virtue is practised by participating, observing, and embodying (Chapter IV). It is also to community that the agent comes back for sustenance and support (section III/A). However, community is also the place where the patient finds a forum for discussion, and help in the decision-making process (section III/B). When the church community understands itself as more than a missionary organisation, its vision will become holistic and include the physical, emotional, and intellectual well-being of its individual members.

At the end of this chapter, and at the close of this dissertation, it becomes clear that in Anabaptist/Mennonite theology and ethics, servanthood, peace and non-violent justice, and community are not viable as individual entities. These three themes emerged as inextricably linked. The Anabaptist/Mennonite concept of

servanthood cannot be learned outside of the community of believers, and peace and non-violent justice cannot be observed and participated in if it is not practised in the community of believers. In addition, the community of believers would not be a community if there were no individual agents who had chosen peace and non-violence as their *modus operandi* in a gathered community. There would be no virtuous agents if there was no such community to provide a forum for servanthood where the virtues can be embodied.

In conclusion, it becomes clear that we are who we are because of the communities that have shaped us. The ethos that shapes us is unmistakably visible in the ethics we embody. But embodiment of this ethic is a choice each individual has to make for themselves, and in basing the choice on Anabaptist/Mennonite theology and ethics the physicians of this study have become a community that is both pulpit and paradigm.

Concluding Reflections

In this dissertation we have advanced the thesis that Anabaptist/Mennonite theology and ethics can make a contribution to make to contemporary debate in biomedical ethics. This thesis has provided the basis for empirical research with Anabaptist/Mennonite physicians. From those interviews three themes have emerged; themes that are important in Anabaptist/Mennonite theology. There are a) servanthood, b) peace and non-violent justice, and c) community. As we have seen in the main body of this dissertation, these three themes are important theological issues which have been discussed within Anabaptist/Mennonite theology and ethics for many decades. Bringing a unique peace church theology to the table of the wider theological and ecumenical discussion has been a particular accomplishment of the late John Howard Yoder, among other Mennonite scholars. It appears that the interviewed physicians have been influenced by Yoder's *Politics of Jesus*; some of the physicians have read *Politics*, as well as other books by Yoder; others have been introduced to Yoder's thought about peace and non-violence through preaching and church teachings.

It is the task of these concluding reflections to address two vital questions. First of all, is this thesis directed towards the Anabaptist community or is it a thesis that is directed from the Anabaptist/Mennonite community to the larger biomedical ethics and theological community? Secondly, how does this particular approach to biomedical ethics relate to more non-particular, or more accurately, universalist ethical approaches? As important as these questions are at the end of this dissertation, we should be under no illusion that we will be able to find the ultimate and final answers in these last pages. These final reflections on the above proposed questions will hopefully become the basis for future academic work in the area of Anabaptist/Mennonite theology and ethics and its contributions to contemporary biomedical ethics.

The Directional Purpose of the Dissertation

The title and sub-title of this dissertation state a twofold directional purpose of the proposed thesis. The title *Whose Ethos? Whose Ethics?* verbalises the challenge of a virtue and agent based ethics towards principle based universalist ethics. As we have seen in the main body of this dissertation, the physicians interviewed show a particular pattern of virtue acquisition through observation-participation-embodiment. IN this context, virtue ethics is learned by the individual agent not as a primary theory, but as a life-style based on theological convictions.

The discussion of a Christian based virtue ethics in Chapter I, as advanced by Joseph Kotva, strongly supports the empirical findings. The issue Kotva has not discussed at length, but which is the main basis of this dissertation, is that virtue theory becomes virtue ethics only when it is embodied in the individual agent's life-style. In the field of biomedical ethics and theology, the step from theoretical principles to ethical practicality is particularly pertinent, as both of these area of study deal closely with human agency.

The subtitle of this dissertation is therefore very specific and seeks to address theological and ethical contributions of Anabaptist/Mennonite scholarship towards issues in contemporary biomedical ethics. This original research has uncovered three specific theological themes which can potentially enhance biomedical ethical scholarship. The most specific, and probably rather uniquely Anabaptist, theme that has emerged is the focus on peace and non-violence as a new focus in contemporary biomedical ethics.⁴⁷⁷ In combination with peace and non-violence, the themes of servanthood and community have been understood in a new and more holistic scope. Our present challenge now is to show that this research poses challenges to the Anabaptist community itself as well as to the wider field of contemporary biomedical ethics.

1. Challenges for the Anabaptist community

The research findings uncover several critical issues which need to be addressed by the Anabaptist community, particularly by the Anabaptist medical community. One of those issues is to understand the importance of the development of virtue ethics within the church community. In connection with a more clearly defined theology of vocation, development of virtue ethics should a high priority of Anabaptist theology. When the pattern of observation-participation and embodiment is linked with a sound theology of vocation, Anabaptist theology and ethics could again become a vitally important voice for Christian social ethics. The physicians themselves have criticised the lack of Anabaptist teaching *and* practice in the area of peace and non-violence in their vocation as physicians. When a young Mennonite grows up with a strong sense of vocation for medicine, s/he also needs to grow up with a strong sense of being grounded in his/her peace church theology. As we have seen, character and virtue developed in the physicians along with their own self-understanding as Mennonites, and it is this particular link that needs renewed attention in the Anabaptist/Mennonite community.

⁴⁷⁷ Cf. Pilot study #1 and interviews # 5+7 particularly.

Aside from a better understanding of the link between virtue development and theology of vocation, another challenge for the Anabaptist community lies in the relationship between master and apprentice. Using the model of Aristotle, or that of Jesus Christ or Paul and Timothy, it is not only virtue and character that develops in this unique relationship between teacher and student. It is in the particular relationship between master and student that theory is transformed into practice. It is one thing to know the theory of Neurosurgery of the brain but it is quite another task to actually operate on a human being's brain successfully. The challenge for the Anabaptist community in general, and the Mennonite Medical Association in particular, is to set into motion a mentoring program where interested young people are paired up with older, experienced adults in a particular field of interest. In the case of MMA, that would mean that college students who plan a career in medicine should be connected with experienced physicians and learn from them. In such a master-apprentice relationship, where particular attention should be given to female students, the students would not only learn to put theories into practice, they would also have a chance to observe the master as a virtuous character.

Another challenge this dissertation poses for the larger Anabaptist medical community is to include peace and non-violence more consciously into their program. As many of the physicians have said, it is one thing to be an excellent physician, but it quite another thing to be an excellent physician who makes peace and non-violence his/her priority in practice.⁴⁷⁸ The history of Mennonite medical missions provides precedence cases of medical missionaries and conscientious objectors who have embodied their peace convictions in civil service and missionary work rather than in war service. FN The peace and non-violence issue needs to be revisited and re-activated, particularly in the area of contemporary biomedical ethics and its multi-faceted challenges. It needs to be emphasised again, as it has been in the discussion in the body of this dissertation, that peace and non-violence can hardly be accomplished without the sustaining and supporting community. Neither can the development and concept of the servant and of servanthood be divorced from the concept of community and of Anabaptist peace theology.

This last challenge is by far the most pressing that Anabaptist/Mennonite theology faces if it is to make contributions to contemporary biomedical ethics. The uniqueness of Anabaptist theology and ethics lies at the heart of peace and non-violent justice and its embodiment in biomedical ethics. The author of this

⁴⁷⁸ Cf. Interview # 3, #5, and #7.

dissertation is keenly aware that these challenges need to be addressed in the continuous study of Anabaptist theology and ethics in relation to contemporary biomedical ethics.

2. Contributions towards contemporary biomedical ethics

This dissertation has dealt with the question what kind of contributions can Anabaptist theology make to the field of contemporary biomedical ethics. Three Anabaptist foci have emerged from the interviews: there is the emphasis on the role of the physician as a servant, the place of community in the formation of that servant, and the tool of peace and non-violence as the operational modus for the servants vocational call.

A) The most prominent contribution of Anabaptist theology and ethics to contemporary biomedical ethics is peace and non-violence as operational modus. The peace emphasis is foundational to Anabaptist theology and ethics, but does not seem to have received much attention in the larger discussion of biomedical ethics. Peace and the best possible alleviation of suffering is the driving force for the work of the physicians in this study. It has become quite clear throughout the study that peace and non-violence are the motivations for the physicians as they see their vocation as an expression of discipleship. In this respect it is impossible for an Anabaptist physician to divide him/herself as the virtuous agent from their relationships with their patients and from the theology and ethics that is the basis for their work. For Anabaptist physicians, peace and non-violence as the motivational force in the treatment of their patients cannot be had if the agent is not convinced that peace has to be a constitutive factor in their own lives. This intextricable link between the peaceful agent and conveying the meaning of peace into his/her work, leads us to another important contribution of Anabaptist/Mennonite theology to the field of contemporary biomedical ethics: the need for renewed attention on the virtual agent that interprets the physician as faithful servant.

B) Servanthood as a concept has not received much attention by contemporary biomedical ethics. However, the physicians of the study have stressed that the attributes of caring, compassion, service and stewardship are essential attributes of the virtuous character of the physician which s/he displays in the relationship with the patients. Since the interviewed physicians are Anabaptist Christians, they focus their thoughts about servanthood and stewardship certainly more on a biblical interpretation of these two concepts. The last part of Chapter V and the second part of Chapter V have dealt extensively with this Anabaptist

interpretation of servanthood. A renewed interpretation of the servant as a virtuous agent might have the potential to have significant impact on questions in biomedical ethics. For instance, a virtuous servant who is the agent over limited resources in a health care setting will take great care that every patient under his/her care is treated fairly. In an era of rapid decline of health care resources this is a difficult task requires patience, determination, much creativity, long-suffering and many more virtues. Renewed interpretations of the meaning of servanthood in biomedical ethics includes not only the tasks of the servant, but also discusses the development of the virtuous character of the agent. Bringing the concept of servanthood to bear on biomedical ethics might thus stress that virtue ethics as a concept is inextricably linked to the virtuous character of the individual agent. Once the link between the theoretical/theological concept and the agent is understood more deeply, we can then hope for a positive change in biomedical ethics and health care, because a concept or theory will only make a difference once the individual agent has been gripped by that theory.

C) A third contribution of Anabaptist theology and ethics to contemporary biomedical ethics is a deeper understanding of community as a source of support for the patient as well as the physicians. Part III of Chapter VI of the dissertation has discussed this issue at length. Anabaptist history can make significant contribution to the introduction of community as a source of strength and support in biomedical ethics. The concept of Mutual Aid and the sharing of resources seem to be concepts that have developed within the so-called peace churches.⁴⁷⁹ Community here is not understood as communitarian ethics, even though that could become one part of it. The need for community in this dissertation lies in the need for support of the patient who goes through medical ethical problems, such as sharing cost for unexpected surgery for instance. Community resources should be utilised in the support of the patient, and in using those resources, fall-outs from health care insurances could be taken care of. A community, be that a church community or a community of friends could pool money, for instance, and help pay the patient's health care premium so that all are covered with basic health care. In the UK health care system, such money could maybe used to pay for costs that are often not covered by insurances, such as payment for prescriptions for regular medication. The creative use of community resources could be used in supporting patients who are standing with their back to the wall of health care insurances.

⁴⁷⁹ Cf. Graydon Snyder, *Health and Medicine in the Anabaptist Tradition*.

A holistic understanding of Community could also become a source of support and encouragement for the physician. Many of the interviewed physicians have lamented the lack of support within their immediate communities. The lack was perceived as a lack of intellectual and spiritual space where they could discuss ethical quandaries without prejudice. Contemporary biomedical ethics needs to take this charge serious, and provide physicians spaces where they can think out loud about ethical ramification of their work without being ostracised and prejudiced against. Local chapters of multidisciplinary discussion groups for health care professionals could be such a forum of support. Annual professional meetings do not seem to be enough support, therefore other forms of community need to lend support to the physicians.

Principlist ethics and virtue ethics

One last question needs to be asked before we can finally end these conclusions. The question is whether, and if so how these findings of a community based virtue ethics relates to the larger discussion of the principled approach of a biomedical ethics. This question has been dealt with at length in Chapter I and can be briefly answered here on two levels. On one hand, there could be no universal principles if individual agents with a virtuous purpose had not established those principles and set them in motion. On the other hand, principled approaches in biomedical ethics are largely dependent on the support of a variety of communities who, as post-modern theory tells us, by and large agree to universal principles as long as they do not interfere too much with the uniqueness of the individual community.

According to the findings of this dissertation it seems to be unedifying to divide ethics categorically into ethics of universal principles vs. ethics of virtues. Universal principles in ethics have not become universal on their own accord. Principles are laws and rules that have been set into place by agents of groups of agents. But this alone does not ensure the principle to become a principle. A principle can only rightly be called a functional principle if agents – as individuals or as communities of individual agents – follow those principles and use them as guidelines in their lives. For instance, the universal principle *primum non nocere* are accepted by all physicians as the major ethical principle. If it was not adhered to, and if it did not matter who did harm to whom for what purpose, than *primum non nocere* would not be a principle per se because it lacks one vital factor, the application of the principle.

Moreover, since most principles in ethics intend to be fair and treat patients with dignity and respect, autonomy and justice, one could safely assume that the agents who put those principles in place were persons of virtue. The principles are set in place for the individual virtuous agent(s) to interpret them and put them into practice. Beauchamp and Childress have pointed out that this interpretative flexibility is exactly what makes their four principles in bioethics so appealing.⁴⁸⁰ The importance of the virtuous agent depends then on how the principles are interpreted and/or followed in each individual case. The interdependence of well-established principles that are interpreted by virtuous agent should therefore be the focus of ethical and theological reasoning in biomedical ethics. It seems to be counterproductive to divide ethical reasoning categorically into principlists and virtue ethicists. According to the physicians of this study, principles and virtues are mutually depended to ensure the best possible treatment of the patient.⁴⁸¹

These thoughts bring us to the last objection that could be raised about this dissertation: how can a communitarian virtue ethics approach be reconciled with a principlist universal approach in biomedical ethics? This objection can best be answered with John Howard Yoder's understanding of ecclesiology. Without repeating the discussion of Chapter V, section C, Yoder stresses two significant theological methods which can be used fruitfully to our present objection: it is the issues of trans-community communication and the church's part in Yoder's idea of being a 'pulpit and paradigm'.

Trans-community communication

Yoder understands the church community to be both a pulpit and a paradigm. From this metaphor various tasks of the church community can be deduced, as described in Chapter V pp. 152 under *The Prophetic Task of the Community of Believers*. Yoder understands the church community to be a paradigm with various patterns of recognition that can be observed by other surrounding communities. He sees the ordinances of the church, baptism, Eucharist, and Worship to be such patterns of recognition. In biomedical ethics, this pattern can be extended, and various patterns of care-taking can be put into place, with which the church community cares for its individual members. In the Middles Ages, for instance, the church was the place where healing of body and soul happened. The monasteries

⁴⁸⁰ Cf. Beauchamp and Childress, *Principles of Biomedical Ethics*. 106f.

⁴⁸¹ Cf. Interview #7 where the physicians was asking the question of principle and its application in relation to Anabaptist physicians and their treatment of teaching of the simple life style.

where the place where the sick were care for, and the physician was not only physical healer, but knew much about spiritual and emotional healing as well.⁴⁸²

Maybe Yoder's challenges to the church to become a paradigm with patterns of recognition needs to be taken seriously in the area of biomedical ethics. For instance it would not be impossible for many churches to establish a fund for medical emergencies which can be used by members of the church who face sudden medical emergencies. Such a fund could not only relieve some funding burden for medical insurances, but it would also be a practical example for other surrounding communities of how the church takes care of its members. This is the passive external task Yoder means when he charges the church to develop paradigmatic pattern of recognition. Such patterns of care taking, for instance, would also serve another very necessary change in the church: to develop holistic ministries rather than focus church teaching only on the saving of souls and thereby neglecting the recognition that we cannot understand ourselves separated from our physical body. Recognising the intricate connections between body, soul, and spirit could mean an entire new are of ministry for many church communities.

When communities have established clear patterns of recognition, when the individual within the community knows which habits have shaped their dispositions, then a valid 'trans-community communication' can begin.⁴⁸³ Yoder developed this methodology as a response to Jeffrey Stout's book *Ethics after Babel*. Where Stout claims that post-modern pluralism has left moral discourse in tatters, Yoder uses the story of the Old Testament and its sixth century prophets, that pluralism is really not such a new concept.⁴⁸⁴ While Yoder argues that the post-modern problem is not pluralism but relativity, we also learn that communities are essentially necessary for human learning, for we learn from the particular setting of the family, then in a particular community and then develop a larger world view. When we have understood which values and communities shape our world-view, then we can enter a valid trans-community communication.

In the biomedical ethics discussion between principlist ethics and virtue this ethics, this concept is a much needed communication device. In conversation between the two communities, it needs to be come clear, that principles are only principles when they are used by a variety of different communities who adapt those

⁴⁸² Cf. Harold J. Cox, "History of Medical Ethics: Medieval Christian Europe". In *EBE*, 1522-1542.

⁴⁸³ For in-depth discussion on habitus-disposition see Chapter V, section C under the heading 'The Hermeneutical Task of the Community of Believers', pp 146.

⁴⁸⁴ Cf. Yoder, John Howard. "Ethics after Babble", 132.

principles to their unique community setting. And the virtue ethics community needs to acknowledge the need for governing principles, even in biomedical ethics. In addition, it also needs to acknowledge, that virtues are not fixed features, but they are also subject to interpretations from within a variety of community settings. The post-modern focus of communities has provided great opportunities to learn from a wide variety of approaches to biomedical ethics. For many, such a variety is threatening, as it challenges ones pre-conceived ideas; however, such challenges also bear the new possibilities for deeper understanding and acceptance. The first step in the discussion between universalist principlists and communitarian virtue ethicists has to be therefore to acknowledge the habitus in which ones ethics have developed. The second step should then be openness for trans-community communication, so that the third step, pro-active change towards common goals can be achieved as well.

Beyond the Dissertation...

This dissertation has its source and its goal beyond the immediacy of serving as the basis for a doctorate. The source of this work lies in my work as a minister to physician members in the congregation where I served before coming to Edinburgh. It was at College Community Mennonite Brethren Church in Clovis, California where, for the first time, I reflected seriously about the struggles Anabaptist/Mennonite physicians face in their daily embodiment of their vocational calling. Thinking more seriously about how the church can minister to physicians began particularly when I learned of the struggle of a physician friend of mine who left her HMO employer partially because she was no longer willing to be pressured to perform abortions. Listening to those musing about the current placement and the relative insecurity of self-employment left me profoundly dissatisfied with the lack of adequate theological reflection I could offer her in this situation. This, and many other bioethical dilemmas in the congregation were the first seeds out of which this dissertation grew.

The goal for this dissertation lies beyond my immediate earning of a doctorate. The goal is that this dissertation will be received by MMA as a constructive stepping-stone towards the development of an Anabaptist/Mennonite approach to biomedical ethics. I would wish that the physicians in this study discover enough creative material in these pages as they try to improve their personal work as physicians, and as they try to contribute to the national health care discussion in the

United States. The Mennonite Health Care Ethics consortium in Goshen, IN has approached me to be part of the discussion about the development of an Anabaptist/Mennonite approach in biomedical ethics. They have specifically requested that I share of the findings of the dissertation. This I will gladly do and relinquish this work so that others can build on it.

Completed narrative analysis is validated by its pragmatic use when others take this work as the basis for their own inquiry.⁴⁸⁵ Sharing the findings of this research with MMA and MHS finally completes the circle of this dissertation and only the future will tell whether and how this dissertation has made a difference.

⁴⁸⁵ Riesman Kohler, *Narrative Analysis*. 68. Cf. Paul Atkinson, *The Ethnographic Imagination*. (New York: Routledge, 1990).

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APPENDIX A

The Case Studies

Issues at the Beginning of Life

Abortion - a situation

The pregnant woman is in her early twenties. She is a lapse Catholic, with no significant religious affiliation at the present time, although she expresses some need for a "church". Her marriage was terminated by divorce; her husband was given custody of three children by that marriage. She had an affair with a man who "befriended" her, but there were no serious prospects for a marriage with him, and the affair has ended. Her family life was as disrupted and as tragic as that which is dramatically presented in Eugene O'Neill's *Long Day's Journey into Night*. Her alcoholic mother mistreated her children, coerced them into deceptive activity for her ends, and was given to periods of violence. Her father has been addicted to drugs, but has managed to continue in business, avoid, incarceration, and provide a decent income for the family. The pregnant woman fled from home after high school to reside in a distant state, and has no significant contact with her parents or siblings. She has two or three friends.

Her pregnancy occurred when she was raped by her former husband and three other men after she had agreed to meet him to talk about their children. The rapes can only be described as acts of sadistic vengeance. She is unwilling to prefer charges against the men, since she believes it would be a further detriment to her children. She has no steady job, partially because of periodic gastro-intestinal illnesses, and has no other income. There are no known physiological difficulties which would jeopardise her life or that of the child. She is unusually intelligent and very articulate and is not hysterical about her situation. Termination of the pregnancy is a live option for her as a way to cope with one of the many difficulties she faces.¹

Issues at the End of Life

The Brophy Case

Paul E Brophy, Sr., a fire-fighter and emergency medical technician in Easton, Massachusetts suffered a ruptured brain artery on March 22, 1983. Surgery was performed in April, but it was unsuccessful, and Brophy never regained consciousness. He was transferred to the New England Sinai Hospital in a persistent vegetative state. When he developed pneumonia in August, both his physicians and Patricia Brophy, his wife and legal guardian, concurred in an order not to resuscitate him if he suggested a cardiac arrest. In December 1983, Mrs Brophy gave the physicians permission for surgical procedure to insert a feeding tube into his stomach. He received seven and a half hours of nursing care each day, consisting of

¹ Gill, Robin. *A Textbook of Christian Ethics*. (Edinburgh: T&T Clark, 1985). 488-489.

bathing, shaving, turning, and so on. Brophy's medical bills, approximately ten thousands dollars per month, were paid entirely by Blue Cross/BlueShield.

Brophy's had often told family members that he did not want to be kept alive if he ever became comatose. In a discussion of the Karen Ann Quinlan case, he had indicated to his wife that "I don't ever want to be on a life-support system. No way do I want to live like that; that's just not living." Several years earlier, the town of Easton had given Brophy and his partner a commendation for bravery after they had pulled a man from a burning truck. When he learned that the victim had suffered a great deal before dying several months after being saved, Brophy threw his commendation in the wastebasket, exclaiming to his wife, "I should have been five minutes later. It would have been all over for him." He told his brother Leo, "If I'm ever like that, just shoot me, pull the plug." And prior to his neuro-surgery, he told one of his daughters, "If I can't sit up and kiss my beautiful daughters, I may as well be six feet under."

Mrs. Brophy, a devout Catholic and a nurse who worked part time with the mentally retarded, decided to question the continuation of artificial feeding when her husband's condition remained unchanged through the next year. There was no hope that he would regain consciousness, and, though he had previously expressed wishes about "pulling the plug." She consulted with clergy, ethicists, and a lawyer before requesting withdrawal of artificial nutrition with the understanding that her husband would die in one to two weeks. Her decision received the unanimous support of their five children and other family members, including Brophy's seven brothers and sister and his elderly mother, who was in her nineties. However, the physicians and the hospital administration refused to act on this request.

In February 1985, Mrs. Brophy asked a probate court for a declaratory judgement ordering the hospital to act affirmatively on their request. The New England Sinai Hospital responded that the physician-in-chief of the hospital could not "in good conscience, consistent with the ethical codes of the medical profession, participate in the discontinuation of all nutrition and hydration." And it requested that Brophy be transferred to another facility if the court ordered discontinuation of artificial nutrition and hydration.

The court-appointed guardian *ad litem* (a person appointed by the court to protect the interest of a ward in a legal proceeding) found that "removal of the G [gastrostomy] tube is not comparable to cessation of dialysis or removal of a respirator because removal of the aforesaid artificial mechanisms permits the illness or injury to run its natural course. Nutrition, however, is not a need required by Mr. Brophy as a result of his illness, but rather, it is a need common to all human beings." Furthermore, the guardian *ad litem* continued, "Brophy is a chronically ill patient, but is not terminally ill. He is entitled to the same fundamentals of comfort, i.e., food, shelter and bedding, as is any other chronically ill patient, and it is duty of the medical facility to provide him with the aforesaid care." The probate judge ruled that the feeding tube must be continued, even though he found that Brophy would have preferred to be dead than to have his life prolonged in a persistent vegetative state and that if competent he would reject artificial nutrition. Mrs. Brophy appealed this verdict.

In September 1986, in a split decision (4 to 3), the Supreme Judicial Court of Massachusetts held that Brophy's feeding tube could be removed. Three U. S.

Supreme Court justices declined to review the decision, The Massachusetts court did both require the hospital to compromise its principles by terminating feeding, but it did require the hospital's co-operation in transferring Brophy to Emerson Hospital in Concord, which was willing to honour Mrs., Brophy's request.

In October 1986, Brophy was transferred to Emerson Hospital under the care of a neurologist who had earlier testified that Brophy was in a persistent vegetative state. Many of the hospital staff volunteered to help care for Brophy by providing supportive care including anticonvulsant and antacids, while he died, Brophy. Age forty-nine, died of pneumonia on October 23, '86, eight days after the feeding tube was removed. He was surrounded by his wife, who had remained with him around the clock, their children, and a grandchild. According to the attending physician, Brophy's death was an "amazing, peaceful, quite time."²

Pre-implantation Genetic Testing

Simon and Claire

Simon and Claire are both in their mid-40s. They have been referred for Preimplantation genetic diagnosis (PIDG) because ten years ago they had a child with FragileX who died six month ago. Since the birth of this child, Claire has had two termination of pregnancy (TOPs) following positive antenatal tests for Fragile X. Following the death of their first child, they are more than ever determined to extend their family, but acknowledge that time is running out for them. Claire is super-ovulated but even so only five gametes are collected. Only two of these become fertilised when mixed with Simon's sperm. Both embryos are affected by Fragile X. Simon and Claire decided that they are getting too old for a child and asked the clinician to implant the embryos. As an alternative, he offers them a place on his IVF waiting list, arguing that they should try IVF with donor gametes. They refuse because they want a child which is genetically related to both of them. He offers further PIDG, they refuse again, concerned that next time they may not even manage to produce a single embryo and that there is no guarantee that even if they do, it will be unaffected by Fragile X. They prefer instead to take the chance that this second child-of pregnancy is established-will be less badly affected than was the first.³

² Beauchamp, Tom and James Childress. *Principles of Biomedical Ethics*. (New York: Oxford University Press, 1994). 522-524.

³ Draper, Heather and Ruth Chadwick. "Beware! Preimplantation genetic diagnosis may solve some old problems but is also raises new ones." *Journal of Medical Ethics*, 1999, 25:114-120.

Preliminary Questions to the Case Studies

1. As Anabaptist medical professional, what would your advise to this person be?
2. What are your arguments concerning abortion, taking into account all circumstance described in the case?
3. Why are the reasons for your advise?
How did you arrive at your conviction

Introduction to Research and Preliminary Demographic Questions

Dear participants,

Thank you for your willingness to be part of this survey and share about your experience of dealing with questions of biomedical ethics in your every day practice. The results of this survey will be a vital part of my Ph. D. dissertation in the department of Christian Ethics and Practical Theology at New College, the divinity department of the University of Edinburgh. Any information disclosed in this survey will be treated as confidential.

If you have any questions and/or suggestions please don't hesitate to contact me, and if you feel you would like to be part of a follow-up interview, please indicate that at the end of the survey. I plan to be in the Washington D. C. area during the first week of July and in the Goshen, Indiana area the second week of October, and if you feel free to be interviewed at that time, please indicated that as well.

Thank you again for your participation, Sylvia

E-mail your responses to

sklaus2@hotmail.com or s.m.klauser@sms.ed.ac.uk or if you receive this survey by mail send it to

Sylvia Klauser

University of Edinburgh, New College Mound Place
Edinburgh, EH1 2LX Scotland

QUESTIONNAIRE

Background Information

For your convenience, just use the space behind/between the questions and type your answers there, thank you.

Name: (optional) Gender: Age:

City and Country of Residence:

How many years are you a practising physician? Your medical specialisation? Name of your denomination?

Are you actively involved in a local church? In what way are you active in your church?

I am willing to volunteer for an interview: (please state your full address/phone/email for further contacts).

Questions for the Pilot Study Interviews

1. How did you decide to become a physician?
2. What kind of influence did Anabaptist theology have in your development and choice of career?
3. Are there cases where your Anabaptist approach as a physician is different from other, more evangelical physician's approaches?
4. What would a unique Anabaptist Medical Ethics look like in your opinion?
5. What should a curriculum in Anabaptist Medical Ethics look like in your opinion?

**Introduction of the Research Project at the
Annual Meeting of the Mennonite Medical Association
Waterloo, Ontario/Canada, June 16-18, 2000**

Attention: All physicians

One of our workshop presenters, **Sylvia M. Klauser, Ph.D. Candidate**, is doing research on "Anabaptists and medical ethics." She would appreciate your willingness to complete the questionnaire on the back of this page and hand it in with your conference evaluation on Sunday morning.

She will also be interviewing some physicians during the convention. You will have an opportunity to volunteer for this.

**A DIFFERENT VOICE. ANABAPTIST THEOLOGY AND ETHICS AS BASIS FOR
DECISION-MAKING IN MEDICAL ETHICS.**

Ph.D. dissertation, Sylvia M. Klauser, Ph.D.Cand., University of Edinburgh, New College, Department of Christian Ethics and Practical Theology.

This dissertation investigates the interrelation of theology and ethics and seeks to apply it to medical ethics.

As example for a theological faith tradition I have chosen the Anabaptist/Mennonite movement. Here we find a clear connection between historical processes as they influence the development of theology and how ethics has seemingly become a result of one's belief/theology.

The Anabaptist/Mennonite focus on peace, justice, and community connects the past with the future like a thread. Of particular interest to this dissertation is the involvement in medical services, specifically the mental hospital movement.

Empirical research is focused on qualitative sampling of stories how one has become involved in medical services, why one decided to become a medical practitioner and what influence Anabaptist theology and ethics had in this decision.

The concluding guidelines of this dissertation might be used for the development of an Anabaptist Medical Ethics.

**Demographic Questionnaire administered to all Mennonite Physicians
Attending MMA in Waterloo, Canada**

June 16-18, 2000

QUESTIONNAIRE

Name (optional):

- Permission to disclose name in study: ☐ yes ☐ no

1. Gender: Female: ☐ male: ☐

2. Age:

3. City and Country of Residence: 4. Overseas medical assignments:

- How many years: from: to:
- As physician: ☐ As student: ☐
- Which organisation did you work with:

5. Experience as physician:

a How many years of experience:

6. Area of Specialisation:

4. Change in Specialisation:

- No ☐
- Yes ☐ Reason(s):

8. Name of Denomination:

9. Name and location of local church:

- How many years active member:
- Areas of service in your local church:

10. Conference involvement:

- No ☐
- Yes ☐ Area(s) of service:

*The information disclosed in this questionnaire will be used as statistical material in the Ph.D. dissertation: A Different Voice: Anabaptist Theology and Ethics as Basis for Decision Making in Medical Ethics. University of Edinburgh, New College, Department of Christian Ethics and Practical Theology. Edinburgh, Scotland.

Questions for the Research Interview

1. When you look back over your life and career, especially to the beginning of your career as a doctor, do any specific teachings of the church stand out in your memory instrumental in your choice of career?
 - were your experiences at all influenced by the Mennonite church and its teachings?
 - are there one or two (or more) teachings of the church that stand out most in your memory?

2. When you think back over your spiritual and theological development can you tell me where ethics is located in that development in your opinion?
 - again, can you highlight for me a few ethical teachings of the church which have been most influential on you as a Mennonite doctor?
 - are there particular times when those teachings surface in your medical practice? If so, can you tell me about these circumstances?
 - in times when the ethical teachings surface in your practice, do you feel it puts you in a bind with professional ethics?

3. Would you say there are particular characteristics of Anabaptist theology and ethics?
 - could you tell me what you think they are?
 - do you think they are at all applicable to your medical practice?

4. Earlier you told me about occasions where Mennonite ethics surfaced in your work. Can you think of a few practical examples when you find your work being heavily influenced by your theological and ethical convictions? Maybe so much so that you had to consult physician or pastor friends to talk things out?
 - do you find certain ethical convictions surface more in your work than others?
 - do you find your ethical convictions colliding with your practise as a physician
 - have you ever thought there might be a relationship between your faith and your ethics?
 - if there is a relationship, on which of the church's teaching would you pinpoint it most significantly?

5. In developing a framework for the practice of medicine, which features of Anabaptist/Mennonite theology and ethics would you expect would be included?
 - from your personal experience as a physician, are there any features which you personally, as a physician, you would definitely favour including?
 - do you think Anabaptist/Mennonite ethics offers a particular approach to medical ethics, something like a special emphasis, which should be considered more in medical ethics?
 - if so, what would it be in your opinion?

6. We have just talked about particular approaches and special features of Anabaptist/Mennonite theology and ethics, if you were asked to write a medical ethics curriculum for a Mennonite college, what would you include in this curriculum?
 - from a Mennonite theology and ethics perspective, what to you seems most important in preparing students to enter medical school?

Coding List

I. Theological-Ethical Issues

1. Peace, peace, non-violence
2. Justice, justice in health care
3. Community, community support indecisions, mutual aid
4. Stewardship
5. Caring
6. Service
7. Compassion
8. Tolerance
9. Lifestyle, Integrity, Congruence of Faith and Action
10. Following Jesus, Sermon on the Mound
11. Civilian Public Service, Conscientious Objector
12. Personal Responsibility before God for actions and life style
13. Kingdom of Priests, Priesthood of all Believers
14. Simple living, simple life
15. Individual worth, Equality, Value of life
16. Working through/grappling with issues
17. Diversity

II. Ethical Issues in Medicine

1. Choice
2. Advocacy for the poor and disadvantaged
3. Healing and holistic Health
4. Abortion
5. Euthanasia-withdrawing
6. Euthanasia-withholding
7. Quality of Life
8. Equal Access to Health Care
9. Justice in Health Care
10. Value of the Individual
11. Decision-making and Administration
12. Intending to die, allowing to die

III. Philosophical Issues

1. Ethics as Life style
2. Ethics undivided from Theology/Belief
3. Supporting Patient's Choice, even though not agreed with it

APPENDIX B

I. CONFESSIONS

1. The Schleithem Confession¹

Brotherly Union of a number of children of God concerning Seven Articles

Translated and edited by John Howard Yoder; The Schleithem Text © Herald Press

The Cover Letter [Introductory]

May joy, peace, mercy from our Father, through the atonement of the blood of Christ Jesus, together with the gifts of one Spirit - who is sent by the Father to all believers to [give] strength and consolation and constance in all tribulation until the end, Amen, be with all who love God and all children of light, who are scattered everywhere, wherever they might have been placed by God our Father, wherever they might be gathered in unity of spirit in one God and Father of us all; grace and peace of heart be with you all. Amen.

Beloved brothers and sisters in the Lord; first and primordially we are always concerned for your consolation and the assurance of your conscience (which was sometime confused), so that you might not always be separated from us as aliens and by right almost completely excluded, but that you might turn to the true implanted members of Christ, who have been armed through patience and the knowledge of self, and thus be again united with us in the power of a godly Christian spirit and zeal for God.

It is manifest with what manifold cunning the devil has turned us aside, so that he might destroy and cast down the work of God, which in us mercifully and graciously has been partially begun. But the true Shepherd of our souls, Christ, who has begun such in us, will direct and teach the same unto the end, to His glory and our salvation, Amen.

Dear brothers and sisters, we who have been assembled in the Lord at Schleithem on the Randen make known, in points and articles, unto all that love God, that as far as

¹ At the time this article was written [translated] (1973) **John Howard Yoder** was teaching at Associated Mennonite Biblical Seminaries, in Elkhart, Indiana. He translated and edited material for *The Legacy of Michael Sattler*, copyright Herald Press, 1973. The copyright to the English version of the Schleithem Text is held by Herald Press, Scottsdale, PA 15683; they have kindly granted permission to make this available on the Web. The Schleithem text is also available in booklet form through bookstores. The HTML conversion of this document was performed by John K. Swartzendruber @ <http://members.iquest.net/~jswartz/schleithem/index.html>

we are concerned, we have been united to stand fast in the Lord as obedient children of God, sons and daughters, who have been and shall be separated from the world in all that we do and leave undone, and (the praise and glory be to God alone) uncontradicted by all the brothers, completely at peace.¹ Herein we have sensed the unity of the Father and of our common Christ as present with us in their Spirit. For the Lord is a Lord of peace and not of quarreling, as Paul indicates (1 Cor. 14:33). So that you understand at what points this occurred, you should observe and understand [what follows]:

A very great offense has been introduced by some false brothers among us, whereby several have turned away from the faith, thinking to practice and observe the freedom of the Spirit and of Christ. But such have fallen short of the truth and (to their own condemnation) are given over to the lasciviousness and license of the flesh. They have esteemed that faith and love may do and permit everything and that nothing can harm nor condemn them, since they are "believers."

Note well, you members of God in Christ Jesus, that faith in the heavenly Father through Jesus Christ is not thus formed: it produces and brings forth no such things as these false brothers and sisters practice and teach. Guard yourselves and be warned of such people, for they do not serve our Father, but their father, the devil.

But for you it is not so; for they who are Christ's have crucified their flesh with all its lusts and desires (Gal. 5:24). You understand me well, and [know] brothers whom we mean. Separate yourselves from them, for they are perverted. Pray the Lord that they may have knowledge unto repentance, and for us that we may have constance to persevere along the path we have entered upon, unto the glory of God and of Christ His Son. Amen.

Article I. Notice Concerning Baptism

Baptism shall be given to all those who have been taught repentance and the amendment of life and [who] believe truly that their sins are taken away through Christ, and to all those who desire to walk in the resurrection of Jesus Christ and be buried with Him in death, so that they might rise with Him; to all those who with such an understanding themselves desire and request it from us; hereby is excluded all infant baptism, the greatest and first abomination of the pope. For this you have the reasons and the testimony of the writings and the practice of the apostles (Mt. 28:19; Mk. 16:6; Acts 2:38; Acts 8:36; Acts 16:31-33; 19:4). We wish simply yet resolutely and with assurance to hold to the same.

Article II. We have been united as follows concerning the ban

We have been united as follows concerning the ban. The ban shall be employed with all those who have given themselves over to the Lord, to walk after [Him]² in His commandments; those who have been baptized into the one body of Christ, and let themselves be called brothers or sisters, and still somehow slip and fall into error and sin, being indavertently overtaken. The same [shall] be warned twice privately and

the third time be publicly admonished before the entire congregation according to the command of Christ (Mt. 18).³ But this shall be done according to the ordering of the Spirit of God before the breaking of bread.⁴ so that we may all in one spirit and in one love break and eat from one bread and drink from one cup.

Article III. Concerning the breaking of bread ...

Concerning the breaking of bread, we have become one and agree thus: all those who desire to break the one bread in remembrance of the broken body of Christ and all those who wish to drink of one drink in remembrance of the shed blood of Christ, they must beforehand be united in the one body of Christ, that is the congregation of God, whose head is Christ, and that by baptism. For as Paul indicates (1 Cor. 10:21), we cannot be partakers at the same time of the table of the Lord and the table of devils. Nor can we at the same time partake and drink of the cup of the Lord and the cup of devils. That is: all those who follow the devil and the world, have no part with those who have been called out of the world unto God. All those who lie in evil have no part in the good

So it shall and must be, that whoever does not share the calling of the one God to one faith, to one baptism, to one spirit, to one body together with all the children of God, may not be made one loaf together with them, as must be true if one wishes truly to break bread according to the command of Christ⁵.

Article IV. We have been united concerning the separation that shall take place ...

We have been united concerning the separation that shall take place from the evil and the wickedness which the devil has planted in the world, simply in this; that we have no fellowship with them,⁶ and do not run with them in the confusion of their abominations. So it is; since all who have not entered into the obedience of faith and have not united themselves with God so that they will to do His will, are a great abomination before God, therefore nothing else can or really will grow or spring forth from them than abominable things. Now there is nothing else in the world and all creation than good or evil, believing and unbelieving, darkness and light, the world and those who are [come] out of the world, God's temple and idols. Christ and Belial, and none will have part with the other.

To us, then, the commandment of the Lord is also obvious, whereby He orders us to be and to become separated from the evil one, and thus He will be our God and we shall be His sons and daughters (2 Cor. 6:17).

Further, He admonishes us therefore to go out from Babylon and from the earthly Egypt, that we may not be partakers in their torment and suffering, which the Lord will bring upon them. (Rev. 18:4 ff.).

From all this we should learn that everything which has not been united with our God in Christ is nothing but an abomination which we should shun. By this are meant all popish and repopish works and idolatry, gatherings, church attendance⁷, winehouses, guarantees and commitments of unbelief, and other things of the kind, which the world regards highly, and yet which are carnal or flatly counter to the command of God, after the pattern of all the iniquity which is in the world. From all this we shall be separated and have no part with such, for they are nothing but abominations, which cause us to be hated before our Christ Jesus, who has freed us from the servitude of the flesh and fitted us for the service of God and the Spirit whom He has given us.

Thereby shall also fall away from us the diabolical weapons of violence - such as sword, armor, and the like, and all of their use to protect friends or against enemies - by virtue of the word of Christ: "you shall not resist evil" (Mt. 5:39).

Article V. We have been united as follows concerning shepherds in the church of God.

We have been united as follows concerning shepherds in the church of God. The shepherd in the church shall be a person according to the rule of Paul⁸, fully and completely, who has a good report of those who are outside the faith. The office of such a person shall be to read and exhort and teach, warn, admonish, or ban in the congregation, and properly to preside among the sisters and brothers in prayer, and in the breaking of bread, and in all things to take care of the body of Christ, that it may be built up and developed, so that the name of God might be praised and honored through us, and the mouth of the mocker be stopped.

He shall be supported, wherein he has need, by the congregation which has chosen him, so that he who serves the gospel can also live therefrom, as the Lord has ordered (1 Cor. 9:14). But should a shepherd do something worthy of reprimand, nothing shall be done with him without the voice of two or three witnesses. If they sin they shall be publicly reprimanded, so that others might fear.²

But if the shepherd should be driven away or led to the Lord by the cross¹⁰ at the same hour another shall be ordained to his place, so that the little folk and the little flock of God may not be destroyed, but be preserved by warning and be consoled.

Article VI. We have been united as follows concerning the sword.

We have been united as follows concerning the sword. The sword is an ordering of God outside the perfection of Christ. It punishes and kills the wicked and guards and protects the good. In the law the sword is established¹¹ over the wicked for punishment and for death and the secular rulers are established to wield the same.

But within the perfection of Christ only the ban is used for the admonition and exclusion of the one who has sinned, without the death of the flesh, simply the warning and the command to sin no more.

Now many, who do not understand Christ's will for us, will ask; whether a Christian may or should use the sword against the wicked for the protection and defense of the good, or for the sake of love.

The answer is unanimously revealed: Christ teaches and commands us to learn from Him, for He is meek and lowly of heart and thus we shall find rest for our souls (Mt. 11:29). Now Christ says to the woman who was taken in adultery (Jn. 8:11), not that she should be stoned according to the law of His Father (and yet He says, "What the Father commanded me, that I do") (Jn. 8:22) but with mercy and forgiveness and the warning to sin no more, says: "Go, sin no more." Exactly thus should we also proceed, according to the rule of the ban.

Second, is asked concerning the sword: whether a Christian shall pass sentence in disputes and strife about worldly matters, such as the unbelievers have with one another. The answer: Christ did not wish to decide or pass judgement between brother and brother concerning inheritance, but refused to do so (Lk. 12:13). So should we also do.

Third, is asked concerning the sword: whether the Christian should be a magistrate if he is chosen thereto. This is answered thus: Christ was to be made King, but He fled and did not discern the ordinance of His Father¹². Thus we should also do as He did and follow after Him, and we shall not walk in darkness. For He Himself says: "Whoever would come after me, let him deny himself and take up his cross and follow me" (Mt. 16:24). He Himself further forbids the violence of the sword when He says: "The princes of this world lord it over them etc., but among you it shall not be so" (Mt. 20:25). Further Paul says, "Whom God has foreknown, the same he has also predestined to be conformed to the image of his Son," etc. (Rom. 8:30). Peter also says: "Christ has suffered (not ruled) and has left us an example, that you should follow after in his steps" (1 Pet. 2:21).

Lastly, one can see in the following points that it does not befit a Christian to be a magistrate: the rule of the government is according to the flesh, that of the Christians according to the spirit. Their houses and dwelling remain in this world, that of the Christians is in heaven. Their citizenship is in this world, that of the Christians is in heaven (Phil. 3:20). The weapons of their battle and warfare are carnal and only against the flesh, but the weapons of Christians are spiritual, against the fortification of the devil. The worldly are armed with steel and iron, but Christians are armed with the armor of God, with truth, righteousness, peace, faith, salvation, and with the Word of God. In sum: as Christ our Head is minded, so also must be minded the members of the body of Christ through Him, so that there be no division in the body, through which it would be destroyed.¹³ Since then Christ is as is written of Him, so must His members also be the same, so that His body may remain whole and unified for its own advancement and upbuilding. For any kingdom which is divided within itself will be destroyed (Mt. 12:25).

Article VII. We have been united as follows concerning the oath

We have been united as follows concerning the oath. The oath is a confirmation among those who are quarreling or making promises. In the law it is commanded that it should be done only in the name of God, truthfully and not falsely. Christ, who teaches the perfection of the law, forbids His [followers] all swearing, whether true or false; neither by heaven nor by earth, neither by Jerusalem nor by our head; and that for the reason which He goes on to give: "For you cannot make one hair white or black." You see, thereby all swearing is forbidden. We cannot perform what is promised in the swearing, for we are not able to change the smallest part of ourselves (Mt. 5:34-37).

Now there are some who do not believe the simple commandment of God and who say, "But God swore by Himself to Abraham, because He was God (as He promised him that He would do good to him and would be his God if he kept His commandments). Why then should I not swear if I promise something to someone?" The answer: hear what the Scripture says: "God, since he wished to prove overabundantly to the heirs of His promise that His will did not change, inserted an oath so that by two immutable things we might have a stronger consolation (for it is impossible that God should lie)" (Heb 6:7 ff.). Notice the meaning of the

passage: God has the power to do what He forbids you, for everything is possible to Him. God swore an oath to Abraham, Scripture says, in order to prove that His counsel is immutable. That means: no one can withstand and thwart His will; thus He can keep His oath. But we cannot, as Christ said above, hold or perform our oath, therefore we should not swear.

Others say that swearing cannot be forbidden by God in the New Testament when it was commanded in the Old, but that it is forbidden only to swear by heaven, earth, Jerusalem, and our head. Answer: hear the Scripture. He who swears by heaven, swears by God's throne and by Him who sits thereon (Mt. 5:35). Observe: swearing by heaven is forbidden, which is only God's throne; how much more is it forbidden to swear by God Himself. You blind fools, what is greater, the throne or He who sits upon it?

Others say, if it is then wrong to use God for truth, then the apostles Peter and Paul also swore.¹⁴ Answer: Peter and Paul only testify to that which God promised Abraham, whom we long after have received. But when one testifies, one testifies concerning that which is present, whether it be good or evil. Thus Simeon spoke of Christ to Mary and testified: "Behold: this one is ordained for the falling and rising of many in Israel and to be a sign which will be spoken against" (Lk 2:34).

Christ taught us similarly when He says: Your speech shall be yea, yea; and nay, nay; for what is more than that comes of evil. He says, your speech or your word shall be

yes and no, so that no one might understand that He had permitted it. Christ is simply yea and nay, and all those who seek Him simply will understand His Word. Amen.¹⁵

Footnotes

1. Beginning with the parenthesis "(the praise and glory be to God alone)," the closing phrases of this paragraph refer not simply to a common determination to be faithful to the Lord, but much more specifically to the actual Schleithem experience and the sense of Unity (*Vereinigung*) which the members had come to in the course of the meeting. "Without contradiction of all the brothers" is the formal description and "completeness at peace" is the subjective definition of this sense of Holy Spirit guidance. Zwingli considered the very report that "we have come together" to be the proof of the culpable, sectarian, conspiratorial character of Anabaptism (*Elenchus*, Z, VI, p.56).
2. *Nachwandeln*, to walk after, is the nearest approximation in the Schleithem text to the concept of discipleship (*Nachfolge*) which was later to become especially current among Anabaptists.
3. This reference to Mt. 18 is the only Scripture reference in the earliest handwritten text. "Rule of Christ" or "Command of Christ" is a standard designation for this text. Cf. J. Yoder: "Binding and Loosing," *Concern* 14, Scottdale, 1967, esp. pp. 15 ff. Other Scripture allusions identified in parentheses have been supplied by later editors. This abundant citation of scriptural language without being concerned to indicate the source of quotation is an indication of the fluency with which Anabaptists thought in biblical vocabulary; it is probably also an indication that they thought of those texts as expressing a meaningful truth rather than as "proof texts."
4. At this point Walter Köhler, the editor of the printed version, suggests the text Mt. 5:23. If "the ordering of the spirit" relates specifically to "before the breaking of bread" and means to point to a Scripture text, this could be a likely one; or 1 Cor. 11 could also possibly be alluded to; but "ordering of the spirit" is not the usual way in which the Anabaptists refer to a Bible quotation. The phrase can also mean a call for a personal and flexible attitude, as the Spirit leads, i.e., in the application of the concern for reconciliation.
5. Most ecumenical debate about the validity of sacraments focuses upon either the sacramental status of the officiant or the doctrinal understanding of the meaning of the emblems. It should be pointed out that the Anabaptist understanding of close communion refers not to the sacrament but to the participants. It is invalidated not by an unauthorized officiant or an insufficient concept of sacrament, but by the absence of real community among those present.
6. Note the shift from "world" to "they." "The world" is not discussed independently of the people constituting the unregenerate order.
7. *Kirchgang*, literally meaning church attendance, has no congregational dimension to it but refers to the conformity to established patterns of those who, while perhaps sympathizing with the Anabaptists, still avoided any public reproach by regularly being seen at the state church functions.
8. 1 Tim. 3:7. Interpreters are not clear where the focus of Art. V lies. Its first thrust is a call for the shepherd to be a morally worthy person, i.e., a critique of the practice of his being appointed on the grounds of his education or social connections without regard to moral stature. Zwingli's translation moves the accent by translating "the shepherd should be one from the congregation," i.e., not someone from elsewhere. As Zwingli knew, the Anabaptists also rejected the naming of a minister to a parish by a distant city council, and he let that

knowledge influence his translation. Previous to 1527, the only generally practiced leadership model was the itinerant. Schleithem shows the consolidation of the *local* small congregation with its own leaders from its midst.

9. The change in number here from "a shepherd" to "if they sin" is explained by the fact that this sentence is a quotation from 1 Tim. 5:20.
10. "Cross" is already by this time a very clear cliché or "technical term" designating martyrdom.
11. "Law" here is a specific reference to the Old Testament. Significantly the verb here is not *verordnet* but merely *geordnet*: conveying less of a sense of permanence or of specific divine institution than "ordained" does. It should be noted that in this entire discussion "sword" refers to the judicial and police powers of the state. There is no reference to war in Art. VI; there had been a brief one in IV.
12. Two interpretations are possible for "did not discern the ordering of His Father." This may mean that Jesus did not respect, as being an obligation for Him, the service in the state in the office of king, even though the existence of the state is a divine ordinance. More likely would be the interpretation that Jesus did not evaluate the action of the people wanting to make Him King as having been brought about (ordered) by His Father.
13. Here the printed version adds Mt. 12:25: "For every kingdom divided against itself will be destroyed."
14. Zwingli's translation fills in the argument here: "If it is bad to swear, or even to use the Lord's name to confirm the truth, then the apostles Peter and Paul sinned: for they swore."
15. This concludes the *Seven Articles*.
16. May mean either: "In the providence of God the Word is preached to us," whereby "Ordnung" would refer to the workings of God in bringing about Reformation and gospel preaching; or "the Word of God is preached according to the divine pattern" with the emphasis on the rediscovery of the true divinely willed church order. The following "whereby" may accordingly refer either to the preaching or to the proper ordering.
17. *Sich üben*: perhaps includes an element of rote learning of gospel narrative and teaching, since literacy and the possession of Bibles was still rare.
18. "Read" includes exposition, "Readings" had been one of the earliest names given to the study meetings held in Zurich and St. Gall prior to the foundation of Anabaptist congregations.
19. "The one to whom God has given the best understanding shall explain it" may mean that, for every particular passage, whoever understands its meaning should speak up. Then we would have a picture of a meeting with no settled leadership, with no controlling role for the "shepherd" who was called for by Schleithem Article V. Then one might infer, as does Jean Seguy, that this text testifies to a time before the Schleithem decisions, when congregations functioned without a named leader. It is, however, also possible that "the one to whom God has given the best understanding" may be a circumlocution for the already recognized leader in the local group.
20. This "reading" may well be rote recitation. This reference to the Psalter is one of the very rare early Anabaptist references to noncongregational devotional exercises. It may be a further trace of an inheritance from monasticism.
21. The common fund is seen here as a special purse for specific needs, not as a total communism of consumption such as was established not much later in Moravia. It is significant that the non-Hutterian Anabaptists also considered themselves to be following the economic example of the early Jerusalem Christians.

22. Rom. 14:17. The assumption that the congregation would frequently gather around a simple meal may be linked to their avoidance of social clubs and guilds (above, Art. IV).
23. The Lord's Supper, specifically identified as such, is evidently distinguished from the rest of the meal, even though both were practiced as often as the brothers met. (Cf. Art. 1.)

2. The Dordrecht Confession of Faith²

Translated by J. C. Wenger

Adopted April 21, 1632, by a Dutch Mennonite Conference held at Dordrecht, Holland.

I. Of God and the Creation of All Things

Since we find it testified that without faith it is impossible to please God, and that he that would come to God must believe that there is a God, and that He is a rewarder of them that seek Him; therefore, we confess with the mouth, and believe with the heart, with all the pious, according to the holy Scriptures, in one eternal, almighty, and incomprehensible God, the Father, Son, and Holy Ghost, and in none more, nor in any other; before whom no God was made or existed, nor shall there be any after Him: for of Him, and through Him, and in Him, are all things; to Him be praise and honor forever and ever, Amen. Heb. 11:6; Deut. 6:4; Gen. 17:1; Isa. 46:8; I John 5:7; Rom. 11:36.

Of this same one God, who worketh all in all, we believe and confess that He is the Creator of all things visible and invisible; that He, in six days, created, made, and prepared, heaven and earth, and the sea, and all that in them is; and that He still governs and upholds the same and all His works through His wisdom, might, and the word of His power. I Cor. 12:6; Gen. I; Acts 14:15.

And when He had finished His works, and had ordained and prepared them, each in its nature and properties, good and upright, according to His pleasure, He created the first man, the father of us Ml, Adam; whom He formed of the dust of the ground, and breathed into his nostrils the breath of life, so that he became a living soul, created by God in His own image and likeness, in righteousness and holiness, unto eternal life. He regarded him above all other creatures, endowed him with many high and glorious gifts, placed him in the pleasure garden or Paradise, and gave him a command and prohibition; afterwards He took a rib from Adam, made a woman therefrom, and brought her to him, joining and giving her to him for a helpmate, companion, and wife; and in consequence of this He also caused, that from this one man Adam, all men that dwell upon the whole earth have descended. Gen. 1:27; 2:7, 17, 18, 22.

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II. Of the Fall of Man

We believe and confess, according to the holy Scriptures, that these our first parents, Adam and Eve, did not continue long in this glorious state in which they were created, but that they, seduced by the subtlety and deceit of the serpent, and the envy of the devil, transgressed the high commandment of God and became disobedient to their Creator; through which disobedience sin has come into the world, and death by sin, which has thus passed upon all men, for that all have sinned, and, hence, brought upon themselves the wrath of God, and condemnation; for which reason they were of God driven out of Paradise, or the pleasure garden, to till the earth, in sorrow to eat of it, and to eat their bread in the sweat of their face, till they should return to the earth, from which they were taken; and that they, therefore, through this one sin, became so ruined, separated, and estranged from God, that they, neither through themselves, nor through any of their descendants, nor through angels, nor men, nor any other creature in heaven or on earth, could be raised up, redeemed, or reconciled to God, but would have had to be eternally lost, had not God, in compassion for His creatures, made provision for it, and interposed with His love and mercy.

Gen. 3:6; IV Esd. 3:7; Rom. 5:12, 18; Gen. 3:23; Ps. 49:8; Rev. 5:9; John 3:16.

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III. Of the Restoration of Man Through the Promise of the Coming Christ

Concerning the restoration of the first man and his posterity we confess and believe, that God, notwithstanding their fall, transgression, and sin, and their utter inability, was nevertheless not willing to cast them off entirely, or to let them be forever lost; but that He called them again to Him, comforted them, and showed them that with Him there was yet a means for their reconciliation, namely, the immaculate Lamb, the Son of God, who had been foreordained thereto before the foundation of the world, and was promised them while they were yet in Paradise, for consolation, redemption, and salvation, for themselves as well as for their posterity; yea, who through faith, had, from that time on, been given them as their own; for whom all the pious patriarchs, unto whom this promise was frequently renewed, longed and inquired, and to whom, through faith, they looked forward from afar, waiting for the fulfillment, that He by His coming, would redeem, liberate, and raise the fallen race of man from their sin, guilt; and unrighteousness. John 1:29; I Pet. 1:19; Gen. 3:15; I John 3:8; 2:1; Heb. 11:13, 39; Gal. 4:4.

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IV. Of the Coming of Christ into This World, and the Purpose for Which He Came

We believe and confess further, that when the time of the promise, for which all the pious forefathers had so much longed and waited, had come and was fulfilled, this previously promised Messiah, Redeemer, and Saviour, proceeded from God, was sent, and, according to the prediction of the prophets, and the testimony of the evangelists, came into the world, yea, into the flesh, was made manifest, and the Word, Himself became flesh and man; that He was conceived in the virgin Mary, who was espoused to a man named Joseph, of the house of David; and that she brought Him forth as her first-born son, at Bethlehem, wrapped Him in swaddling

clothes, and laid Him in a manger. John 4:25; 16:28; I Tim. 3:16; John 1:14; Matt. 1:23; Luke 2:7.

We confess and believe also, that this is the same whose goings forth have been from of old, from everlasting, without beginning of days, or end of life; of whom it is testified that He Himself is the Alpha and Omega, the beginning and the ending, the first and the last; that He is the same, and no other, who was foreordained, promised, sent, and came into the world; who is God's only, first and own Son; who was before John the Baptist, before Abraham, before the world; yea, who was David's Lord, and the God of the whole world, the first-born of every creature; who was brought into the world, and for whom a body was prepared, which He yielded up as a sacrifice and offering, for a sweet savor unto God, yea, for the consolation, redemption, and salvation of all mankind. John 3:16; Heb. 1:6; Rom. 8:32; John 1:30; Matt. 22:43; Col. 1:15; Heb. 10:5.

But as to how and in what manner this precious body was prepared, and how the Word became flesh, and He Himself man, in regard to this we content ourselves with the statement pertaining to this matter which the worthy evangelists have left us in their accounts, according to which we confess with all the saints, that He is the Son of the living God, in whom alone consist all our hope, consolation, redemption, and salvation, which we neither may nor must seek in any other. Luke 1:31, 32; John 20:31; Matt. 16:16.

We furthermore believe and confess with the Scriptures, that, when He had finished His course, and accomplished the work for which He was sent and came into the world, He was, according to the providence of God, delivered into the hands of the unrighteous; suffered under the judge, Pontius Pilate; was crucified, dead, was buried, and on the third day, rose from the dead, and ascended to heaven; and that He sits on the right hand of God the Majesty on high, whence He will come again to judge the quick and the dead. Luke 22:53; 23:1; 24:6, 7, 51.

And that thus the Son of God died, and tasted death and shed His precious blood for all men; and that He thereby bruised the serpent's head, destroyed the works of the devil, annulled the handwriting and obtained forgiveness of sins for all mankind; thus becoming the cause of eternal salvation for all those who, from Adam unto the end of the world, each in his time, believe in, and obey Him. Gen. 3:15; I John 3:8; Col. 2:14; Rom. 5:18.

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V. Of the Law of Christ, i.e., the Holy Gospel or the New Testament

We also believe and confess that before His ascension He instituted His New Testament, and, since it was to be and remain an eternal Testament, that He confirmed and sealed the same with His precious blood, and gave and left it to His disciples, yea, charged them so highly with it, that neither angel nor man may alter it, nor add to it nor take away from it; and that He caused the same, as containing the whole counsel and will of His heavenly Father, as far as is necessary for salvation to be proclaimed in His name by His beloved apostles, messengers, and ministers-whom He called, chose, and sent into all the world for that purpose-among all peoples, nations, and tongues; and repentance and remission of sins to be preached

and testified of; and that He accordingly has therein declared all men without distinction, who through faith, as obedient children, heed, follow, and practice what the same contains, to be His children and lawful heirs; thus excluding no one from the precious inheritance of eternal salvation, except the unbelieving and disobedient, the stiff-necked and obdurate, who despise it, and incur this through their own sins, thus making themselves unworthy of eternal life. Jer. 31:31; Heb. 9:15-17; Matt. 26:28; Gal. 1:8; I Tim. 6:3; John 15:15; Matt. 28:19; Mark 16:15; Luke 24:47; Rom. 8:17; Acts 13:46.

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VI. Of Repentance and Reformation of Life

We believe and confess, that, since the imagination of man's heart is evil from his youth, and, therefore, prone to all unrighteousness, sin, and wickedness, the first lesson of the precious New Testament of the Son of God is repentance and reformation of life, and that, therefore, those who have ears to hear, and hearts to understand, must bring forth genuine fruits of repentance, reform their lives, believe the Gospel, eschew evil and do good, desist from unrighteousness, forsake sin, put off the old man with his deeds, and put on the new man, which after God is created in righteousness and true holiness: for, neither baptism, supper, church [membership], nor any other outward ceremony, can without faith, regeneration, change or renewing of life, avail anything to please God or to obtain of Him any consolation or promise of salvation; but we must go to God with an upright heart, and in perfect faith, and believe in Jesus Christ, as the Scripture says, and testifies of Him; through which faith we obtain forgiveness of sins, are sanctified, justified, and made children of God, yea, partake of His mind, nature, and image, as being born again of God from above, through incorruptible seed. Gen. 8:21; Mark 1:15; Ezek. 12:2; Col. 3:9, 10; Eph. 4:22, 24; Heb. 10:22, 23; John 7:38.

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VII. Of Holy Baptism

Concerning baptism we confess that ~l penitent believers, who, through faith, regeneration, and the renewing of the Holy Ghost, are made one with God, and are written in heaven, must, upon such Scriptural confession of faith, and renewing of life, be baptized with water, in the most worthy name of the Father, and of the Son, and of the Holy Ghost, according to the command of Christ, and the teaching, example, and practice of the apostles, to the burying of their sins, and thus be incorporated into the communion of the saints; henceforth to learn to observe all things which the Son of God has taught, left, and commanded His disciples. Acts 2:38; Matt. 28:19, 20; Rom. 6:4; Mark 16:16; Matt. 3:15; Acts 8:16; 9:18; 10:47; 16:33; Col. 2:11, 12.

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VIII. Of the Church of Christ

We believe in, and confess a visible church of God, namely, those who, as has been said before, truly repent and believe, and are rightly baptized; who are one with God in heaven, and rightly incorporated into the communion of the saints here on earth. These we confess to be the chosen generation, the royal priesthood, the holy nation,

who are declared to be the bride and wife of Christ, yea, children and heirs of everlasting life, a tent, tabernacle, and habitation of God in the Spirit, built upon the foundation of the apostles and prophets, of which Jesus Christ Himself is declared to be the cornerstone (upon which His church is built). This church of the living God, which He has acquired, purchased, and redeemed with His own precious blood; with which, according to His promise, He will be and remain always, even unto the end of the world, for consolation and protection, yea, will dwell and walk among them, and preserve them, so that no floods or tempests, nay, not even the gates of hell, shall move or prevail against them--this church, we say, may be known by their Scriptural faith, doctrine, love, and godly conversation, as, also, by the fruitful observance, practice, and maintenance of the true ordinances of Christ, which He so highly enjoined upon His disciples. I Cor. 12; I Pet. 2.9; John 3.29; Rev. 19.7; Titus 3:6, 7; Eph. 2:19-21; Matt. 16.18; I Pet. 1.18, 19; Matt. 28.20; II Cor. 6:16; Matt. 7:25.

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IX. Of the Election, and Offices of Teachers, Deacons, and Deaconesses in the Church

Concerning the offices and elections in the church, we believe and confess, that, since without offices and ordinances the church cannot subsist in her growth, nor continue in building, therefore the Lord Jesus Christ Himself, as a husbandman in His house, has instituted, ordained, enjoined, and commanded His offices and ordinances, how everyone is to walk therein, and give heed to and perform His work and calling, as is meet, even as He Himself, as the faithful, great, chief Shepherd and Bishop of our souls, was sent, and came into the world, not to bruise, break, or destroy the souls of men, but to heal and restore them, to seek the lost, to break down the middle wall of partition, to make of twain one, and thus to gather of Jews, Gentiles, and all nations, one flock, for a church in His name, for which--that no one should err or be lost--He Himself laid down His life, thus ministering to their salvation, and liberating and redeeming them, (mark) wherein no one else could help or assist them. Eph. 4:10-12; I Pet. 2:25; Matt 12:19 18:11 Eph. 2:14; Gal. 3:28; John 10:9, 11, 15; Ps. 49:8.

And that He, moreover, before His departure, left His church supplied with faithful ministers, apostles, evangelists, pastors, and teachers, whom He before, through the Holy Ghost, had chosen with prayer and supplication; that they might govern the church, feed His flock, and watch over, protect, and provide for it, yea, do in all things, as He had done before them, had taught, by example shown, and charged them, to teach to observe all things whatsoever He had commanded them. Luke 10:1; 6:12, 13; John 2:15.

That the apostles, likewise, as faithful followers of Christ, and leaders of the church, were diligent in this respect, with prayer and supplication to God, through the election of brethren, to provide every city, place, or church, with bishops, pastors, and leaders, and to ordain such persons thereto, who would take heed unto themselves, and unto the doctrine and flock, who were sound in faith, pious in life and conversation, and of good report without as well as in the church; that they might be an example, light, and pattern in all godliness and good works, worthily administering the Lord's ordinances--baptism and supper--and that they might

everywhere (where such could be found) appoint faithful men who would be able to teach others also, as elders, ordaining them by the laying on of hands in the name of the Lord, and provide for all the wants of the church according to their ability; so that, as faithful servants, they might husband well their Lord's talent, get gain with it, and, consequently, save themselves and those who hear them. I Tim. 3:1; Acts 23:24; Titus 1:5; I Tim. 4:16; Titus 2:1, 2; I Tim. 3:7; II Tim. 2:2; I Tim. 4:14; 5:2; Luke 19:13.

That they should also see diligently to it, particularly each among his own over whom he has the oversight, that all places be well provided with deacons (to look after and care for the poor), who may receive the contributions and alms, in order to dispense them faithfully and with all propriety to the poor and needy saints. Acts 6:3-6.

And that also honorable aged widows should be chosen and ordained deaconesses, that they with the deacons may visit, comfort, and care for, the poor, feeble, sick, sorrowing and needy, as also the widows and orphans, and assist in attending to other wants and necessities of the church to the best of their ability. I Tim. 5:9; Rom. 16:1; Jas. 1:27.

Furthermore, concerning deacons, that they, especially when they are fit, and chosen and ordained thereto by the church, for the assistance and relief of the elders, may exhort the church (since they, as has been said, are chosen thereto), and labor also in the Word and in teaching; that each may minister unto the other with the gift he has received of the Lord, so that through mutual service and the assistance of every member, each in his measure, the body of Christ may be improved, and the vine and church of the Lord continue to grow, increase, and be built up, according as it is proper.

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X. Of the Holy Supper

We also confess and observe the breaking of bread, or Supper, as the Lord Christ Jesus before His suffering instituted it with bread and wine, and observed and ate with His apostles, commanding them to observe it in remembrance of Him; which they accordingly taught and practiced in the church, and commanded that it should be kept in remembrance of the suffering and death of the Lord; and that His precious body was broken, and His blood shed, for us and all mankind, as also the fruits hereof, namely, redemption and eternal salvation, which He purchased thereby, showing such great love toward us sinful men; whereby we are admonished to the utmost, to love and forgive one another and our neighbor, as He has done unto us, and to be mindful to maintain and live up to the unity and fellowship which we have with God and one another, which is signified to us by this breaking of bread. Matt. 26:26; Mark 14:22; Acts 2:42; I Cor. 10:16; 11:23.

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XI. Of the Washing of the Saints' Feet

We also confess a washing of the saints' feet, as the Lord Christ not only instituted, enjoined and commanded it, but Himself, although He was their Lord and Master,

washed His apostles' feet, thereby giving an example that they should likewise wash one another's feet, and do as He had done unto them; which they accordingly, from this time on, taught believers to observe, as a sign of true humility, and, especially, to remember by this feet washing, the true washing, whereby we are washed through His precious blood, and made pure after the soul. John 13:4-17; I Tim. 5:10.

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XII. Of the State of Matrimony

We confess that there is in the church of God an honorable state of matrimony, of two free, believing persons, in accordance with the manner after which God originally ordained the same in Paradise, and instituted it Himself with Adam and Eve, and that the Lord Christ did away and set aside all the abuses of marriage which had meanwhile crept in, and referred all to the original order, and thus left it. Gen. 1:27; Mark 10:4.

In this manner the Apostle Paul also taught and permitted matrimony in the church, and left it free for every one to be married, according to the original order, in the Lord, to whomsoever one may get to consent. By these words, in the Lord, there is to be understood, we think, that even as the patriarchs had to marry among their kindred or generation, so the believers of the New Testament have likewise no other liberty than to marry among the chosen generation and spiritual kindred of Christ, namely, such, and no others, who have previously become united with the church as one heart and soul, have received one baptism, and stand in one communion, faith, doctrine and practice, before they may unite with one another by marriage. Such are then joined by God in His church according to the original order; and this is called, marrying in the Lord. II Cor. 7:2; I Cor. 9:5; Gen. 24:4; 28:2; I Cor. 7:39.

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XIII. Of the Office of the Secular Authority

We believe and confess that God has ordained power and authority, and set them to punish the evil, and protect the good, to govern the world, and maintain countries and cities, with their subjects, in good order and regulation; and that we, therefore, may not despise, revile, or resist the same, but must acknowledge and honor them as the ministers of God, and be subject and obedient unto them, yea, ready for all good works, especially in that which is not contrary to the law, will, and commandment of God; also faithfully pay custom, tribute, and taxes, and to render unto them their dues, even also as the Son of God taught and practiced, and commanded His disciples to do; that we, moreover, must constantly and earnestly pray to the Lord for them and their welfare, and for the prosperity of the country, that we may dwell under its protection, earn our livelihood, and lead a quiet, peaceable life, with all godliness and honesty; and, furthermore, that the Lord would recompense unto them, here, and afterwards in eternity, all benefits, liberty, and favor which we enjoy here under their praiseworthy administration. Rom. 13:1-7; Titus 3:1; I Pet. 2:17; Matt. 22:21; 17:27; I Tim. 2:1.

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XIV. Of Revenge

As regards revenge, that is, to oppose an enemy with the sword, we believe and confess that the Lord Christ has forbidden and set aside to His disciples and followers all revenge and retaliation, and commanded them to render to no one evil for evil, or cursing for cursing, but to put the sword into the sheath, or, as the prophets have predicted, to beat the swords into ploughshares. Matt. 5:39, 44; Rom. 12:14; I Pet. 3:9; Isa. 2:4; Micah 4:3; Zech. 9:8, 9.

From this we understand that therefore, and according to His example, we must not inflict pain, harm, or sorrow upon any one, but seek the highest welfare and salvation of all men, and even, if necessity require it, flee for the Lord's sake from one city or country into another, and suffer the spoiling of our goods; that we must not harm any one, and, when we are smitten, rather turn the other cheek also, than take revenge or retaliate. Matt. 5:39.

And, moreover, that we must pray for our enemies, feed and refresh them whenever they are hungry or thirsty, and thus convince them by well-doing, and overcome all ignorance. Rom. 12:19, 20.

Finally, that we must do good and commend ourselves to every man's conscience; and, according to the law of Christ, do unto no one that which we would not have done to us. II Cor. 4:2; Matt. 7:12.

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XV. Of the Swearing of Oaths

Concerning the swearing of oaths we believe and confess that the Lord Christ has set aside and forbidden the same to His disciples, that they should not swear at all, but that yea should be yea, and nay, nay; from which we understand that all oaths, high and low, are forbidden, and that instead of them we are to confirm all our promises and obligations, yea, all our declarations and testimonies of any matter, only with our word yea, in that which is yea, and with nay, in that which is nay; yet, that we must always, in all matters, and with everyone, adhere to, keep, follow, and fulfill the same, as though we had confirmed it with a solemn oath. And if we do this, we trust that no one, not even the Magistracy itself, will have just reason to lay a greater burden on our mind and conscience. Matt. 5:34, 35; Jas. 5:12; II Cor. 1:17.

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XVI. Of the Ecclesiastical Ban, or Separation from the Church

We also believe in, and confess, a ban, separation, and Christian correction in the church, for amendment, and not for destruction, in order to distinguish that which is pure from the impure: namely, when any one, after he is enlightened, has accepted the knowledge of the truth, and been incorporated into the communion of the saints, sins again unto death, either through willfulness, or through presumption against God, or through some other cause, and falls into the unfruitful works of darkness, thereby becoming separated from God, and forfeiting the kingdom of God, that such a one, after the deed is manifest and sufficiently known to the church, may not remain in the congregation of the righteous, but, as an offensive member and open sinner, shall and must be separated, put away, reprov'd before all, and purged out as leaven; and this for his amendment, as an example, that others may fear, and to keep

the church pure, by cleansing her from such spots, lest, in default of this, the name of the Lord be blasphemed, the church dishonored, and offense given to them that are without; and finally, that the sinner may not be condemned with the world, but become convinced in his mind, and be moved to sorrow, repentance, and reformation. Jer. 59:2; I Cor. 5:5, 13; I Tim. 5:20; I Cor. 5:6; II Cor. 10:8; 13:10.

Further, concerning brotherly reproof or admonition, as also the instruction of the erring it is necessary to exercise all diligence and care, to watch over them and to admonish them with all meekness, that they may be bettered, and to reprove, according as is proper, the stubborn who remain obdurate; in short, the church must put away from her the wicked (either in doctrine or life), and no other. Jas. 5:19; Titus 3:10; I Cor. 5:13.

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XVII. Of Shunning the Separated

Concerning the withdrawing from, or shunning the separated, we believe and confess, that if any one, either through his wicked life or perverted doctrine, has so far fallen that he is separated from God, and, consequently, also separated and punished by the church, the same must, according to the doctrine of Christ and His apostles, be shunned, without distinction, by all the fellow members of the church, especially those to whom it is known, in eating, drinking, and other similar intercourse, and no company be had with him that they may not become contaminated by intercourse with him, nor made partakers of his sins; but that the sinner may be made ashamed, pricked in his heart, and convicted in his conscience, unto his reformation. I Cor. 5:9-11; II Thess. 3:14.

Yet, in shunning as well as in reproof, such moderation and Christian discretion must be used, that it may conduce, not to the destruction, but to the reformation of the sinner. For, if he is needy, hungry, thirsty, naked, sick, or in any other distress, we are in duty bound, necessity requiring it, according to love and the doctrine of Christ and His apostles, to render him aid and assistance; otherwise, shunning would in this case tend more to destruction than to reformation.

Therefore, we must not count them as enemies, but admonish them as brethren, that thereby they may be brought to a knowledge of and to repentance and sorrow for their sins, so that they may become reconciled to God, and consequently be received again into the church, and that love may continue with them, according as is proper. II Thess. 3:15.

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XVIII. Of the Resurrection of the Dead, and the Last Judgment

Finally, concerning the resurrection of the dead, we confess with the mouth, and believe with the heart, according to Scripture, that in the last day all men who shall have died, and fallen asleep, shall be awaked and quickened, and shall rise again, through the incomprehensible power of God; and that they, together with those who then will still be alive, and who shall be changed in the twinkling of an eye, at the sound of the last trump, shall be placed before the judgment seat of Christ, and the good be separated from the wicked; that then everyone shall receive in his own body

according to that he hath done, whether it be good or evil; and that the good or pious, as the blessed, shall be taken up with Christ, and shall enter into life eternal, and obtain that joy, which eye hath not seen, nor ear heard, neither hath entered into the heart of man, to reign and triumph with Christ forever. and ever. Matt. 22:30, 31; Dan. 12:12; Job 19:26, 27; Matt. 25:31; John 5:28; II Cor. 5:10; I Cor. 15; Rev. 20:12; I Thess. 4:15; I Cor. 2:9.

And that, on the other hand, the wicked or impious, as accursed, shall be cast into outer darkness, yea, into the everlasting pains of hell, where their worm shall not die, nor their fire be quenched, and where they, according to holy Scripture, can nevermore expect any hope, comfort, or redemption. Mark 9:44; Rev. 14:11.

May the Lord, through His grace, make us all worthy and meet, that this may befall none of us; but that we may thus take heed unto ourselves, and use all diligence, that on that day we may be found before Him unspotted and blameless in peace. Amen.

These, then, as has been briefly stated before, are the principal articles of our general Christian faith, as we teach and practice the same throughout in our churches and among our people; which, in our judgment, is the only true Christian faith, which the apostles in their time believed and taught, yea, testified with their life, confirmed with their death, and, some of them, also sealed with their blood; wherein we in our weakness with them and all the pious, would fain abide, live, and die, that we 'may afterwards obtain salvation with them through the grace of the Lord.

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Thus done and finished in our united churches, in the city of Dordrecht, the 21st of April, 1632, new style.

[Signers given in Van Braght: Martyrs' Mirror, page 44.]

ADOPTION BY THE ALSATIAN MENNONITES, 1660

We, the undersigned, ministers of the word of God, and elders of the church in Alsace, hereby declare and make known, that being assembled this 4th of February in the year of our Lord 1660, at Ohnenheim in the principality of Rappoltstein, on account of the Confession of Faith, which was adopted at the Peace Convention of the Taufels-gesinnten which are called the Flemish, in the city of Dort, on the 21st day of April in the year 1632, and which was printed at Rotterdam by Franciscus von Hochstraten, Anno 1658; and having examined the same, and found it in agreement with our judgment, we have entirely adopted it as our own.

[Signers given in Wenger: Glimpses of Mennonite History and Doctrine (Scottsdale, Pa.: Mennonite Publishing House, 1949), page 227.]

ADOPTION BY THE MENNONITES OF AMERICA, 1725

We the hereunder written Servants of the Word of God, and Elders in the Congregation of the People called, Mennonists, in the Province of Pennsylvania, do acknowledge, and herewith make known, That we do own the afore-going Confession, Appendix, and Menno's Excusation, to be according to our Opinion: and also have took the same to be wholly ours.

[Signers given in Wenger: History of the Mennonites of the Franconia Conference

(Telford, Pa.: Franconia Mennonite Historical Society, 1937), page 318.]

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II. HEALTH CARE STATEMENTS

MCC U.S. Statement on Abortion

(Draft May 21, 2001)

Abortion has become a public issue with lines of debate sharply drawn. Much debate stems from different perceptions of when life begins. Many differences reflect varied priorities and values: for some the primary value is preservation of human life; for others it is quality of life. The Mennonite and Brethren in Christ churches have long affirmed that God wills abundant life for all people, and have been concerned with both the preservation and the quality of life. These concerns have been expressed in opposition to war, military conscription and capital punishment. They have also been expressed in positive efforts to enhance the dignity and sanctity of human life, such as work to alleviate poverty through relief and development projects. We affirm the statements and guidelines on abortion adopted by the Mennonite and Brethren in Christ conferences. In harmony with these statements, we affirm the following:

Sanctity of Human Life:

- We accept the Bible as the written form of God's revelation to us and the ultimate guide for faith and practice.ⁱ
- We understand the Bible to teach that people are created in the image of God and that all human life is sacred.ⁱⁱ
- We affirm that the Bible reflects special concern for the poor, the weak, the helpless, the stranger, the widow and the orphan.ⁱⁱⁱ
- We believe that all forms of violence, including abortion, are not the will of God.^{iv}

Responses to Abortion:

Attitudes:

- In light of the spiritual and ethical erosion in our society, we need to accept our responsibility to recognize and protect the sanctity of human life.^v
- We affirm and commit ourselves to develop attitudes of social acceptance of the single parent, male and female, without endorsing their actions leading to the pregnancy.^{vi}

- We commit to show concern for the individuals who decide to relinquish their children, as well as seek to prevent the suffering, often a living death, of unwanted children by providing adoptive homes and other support systems.^{vii}
- We appeal for prayerful support of those who are confronted with hard decisions and for a spirit of sensitivity and Christian love toward those who view this issue from a different perspective. The Scriptures teach us not to look with punitive judgment on those who differ but to be sensitive toward their situation and surround them with care and compassion. Jesus' harshest words were directed against the self-righteous.^{viii}

Actions:

- We commit to encourage preventive measures and alternatives to abortion, as well as support for the persons who make these decisions; such as counseling resources, adoption, economic assistance (like subsidized childcare and welfare), caring facilities for those who choose to let their pregnancy go full-term, foster-parenting, and supporting families with developmentally disabled children.^{ix}
- We acknowledge that, whether legal or illegal, women in desperate circumstances will continue to seek abortions. We commit to work toward a world in which the ills of a materialistic dehumanizing society would be cured by divine love and acceptance and thus eliminate this need.^x
- We commit to provide Christian education in the meaning and responsible expression of human sexuality for both young and old, male and female.^{xi}
- We commit to inform ourselves and our constituency of a realistic understanding of the whole issue of abortion with its related considerations, and give expression to such understanding as we have opportunity.^{xii}

Notes:

ⁱ Similar statement included in the Statement on Abortion approved by the General Conference of the Brethren in Christ Church, 1986. Biblical references: Psalms 19:7-8, Prov. 3:1-2

ⁱⁱ Similar statement included in the Statement on Abortion approved by the General Conference of the Brethren in Christ Church, 1986. Biblical references: Gen. 1:27

ⁱⁱⁱ Similar statement included in the Statement on Abortion approved by the General Conference Mennonite Church, July 17, 1980. Biblical references: Deut. 24:10-22, Matt. 25:34-40, Luke 4:18, James 2:1-5, 14-16

^{iv} Similar statement included in Article 22 of the Confession of Faith in a Mennonite Perspective adopted at the delegate sessions of the General Conference Mennonite Church and the Mennonite Church, July 25-30, 1995. Biblical references: Eph. 4:1-3

^v Similar statement included in the Mennonite Church Statement on Abortion adopted by the Mennonite General Assembly, August 1975. Biblical references: Deut. 30:19, Mark 12:31, John 10:10

^{vi} Similar statement included in the Mennonite Brethren Church Stance on Abortion Issues adopted at the 1972 General Conference. Biblical references: Matt. 5:44-47, Matt. 6:14-15, John 8:11

^{vii} Similar statement included in the Guidelines on Abortion adopted by the General Conference Mennonite Church, July 17, 1980. Biblical references: John 18:16

^{viii} Parts of this statement are found in the General Conference Mennonite Church, Mennonite Church and brethren in Christ statements on abortion. Biblical references: Matt. 7:1-5, John 8:7

^{ix} Parts of this statement are found in the General Conference Mennonite Church, Mennonite Church and Mennonite Brethren statements on abortion. Biblical references: Matt. 25:34-40, John 18:16

^x Similar statement included in the Mennonite Church Statement on Abortion adopted by the Mennonite General Assembly, August 1975. Biblical references: John 13:34-35

^{xi} Similar statement included in Article 22 of the Confession of Faith in a Mennonite Perspective adopted at the delegate sessions of the General Conference Mennonite Church and the Mennonite Church, July 25-30, 1995. Biblical references: I Cor. 7:1-5, Heb. 13:4

^{xii} Similar statement included in the Mennonite Brethren Church Stance on Abortion Issues adopted at the 1972 General Conference. Biblical references: Prov. 10:14, 15:7

APPENDIX C

THE INTERVIEWS

Editorial Note:

The email responses, pilot study interviews, and main interviews were transcribed by me personally. For the sake of authenticity, I have decided to do as little editorial work as possible and leave the interviews in their most original state. I have tried to be sparse with editorial editions in square brackets, therefore, the following pages might be somewhat difficult to read.

The individual interviews can be identified by their titles in the header of the pages. There are firstly, Email responses, which refer to the interviews about the case studies at the very beginning of the research project. Secondly, there are two pilot study interviews which were taped as a result of the email responses. And lastly, there are the main interviews. Those are numbered from 1-10 in the order in which they were used in the main text.

Each interview has line numbers appearing on the left margin. These numbers help to identify the quotes as they appear in the main text of the dissertation.

BACKGROUND INFORMATION

Louis Janzen, Fresno, California, USA. Practising physician, 38 years, paediatrics, Mennonite Brethren, actively involved in local church, variously, most recently in stewardship and choir.

Case #1: Legally, I don't think any society would refuse an abortion for the woman in question. Some religious policies would. My feelings respect [the] mother's choice for or against termination of the pregnancy. She may very well want to keep the child despite any questions of paternity and rape. One would especially then wish for emotional, psychological, and spiritual as well as physical help for both the mother and the child. I would refer her to a rape counselling service and abortion if she wishes. Her history of past problems makes for a high-risk family situation. Church or community group support is highly recommended.

Case #2: Two of my Protestant colleagues, close friends, were caring for an elderly comatose patient in a local nursing home a few years ago. The family requested feeding tube removal. The situation was discussed with the caring staff and the tube was withdrawn, and the patient subsequently soon died. Later one staff person took them to court, and they were charged with murder. They were released from prison on bail. The charge was murder and not malpractice, and therefore medical liability did not cover any of the legal defence or expense. The case was publicized and both doctors were forced to stop their practice of medicine, even though they were eventually declared not guilty. One person with a strong right-to-life conviction, and a lawyer hoping for a quick out of court settlement nearly destroyed the lives of two friends.

Nursing homes as well as hospitals have been under strong governmental scrutiny to enforce feedings. This was quite apparent when Jean's mother was terminal with heart failure at 96 years. She asked to die in nearly every conversation, her weight loss [was] down to less than half of her usual weight. The staff persisted in attempting to feed her, and prolonged her misery.

The status of maintaining life in this fashion has been debated in the medical-legal community for many years, and there is no likely solution that is perfect for every situation. Much legislation involving medicine is functionally made in the courts, and at times frightens me from doing what I think may be best for the patient.

Case #3: The case study is very interesting to me. First of all, I consulted with one of our geneticists at Valley Children's Hospital (part of the U. C. San Francisco medical faculty.) In a busy service with 3-4 physicians in a field that is changing rapidly, as an Anabaptist physician I use the best consultants available. I was told that there is currently more information about Fragile X on [the] internet than we could read in three weeks. The information I received in five minutes or so would require in practice a full, extensive consultation. First of all, the problem is not due to the sperm, so IVF with non-parent donor sperm would not reduce the risk of Fragile X. The genetic defect is in the DNA of the ovum, a "trinucleotide repeat", and the number of repeats in the specific ovum determines the severity of the Fragile X. It is variable. Furthermore, it is sex-linked in the X chromosome that is variably

49 affected. Therefore, the risk is only to boys. A girl should not be affected. The
50 geneticist reports that this is high-tech stuff, trying to determine the number of
51 defects, the degree of abnormality in the ovum DNA.
52 My geneticist said she would refuse to implant a known defective embryo. "We have
53 too many genetic abnormalities without knowingly creating more." However, with
54 the parents' wishes, they could try for a natural pregnancy and accept the risks which
55 they are prepared to do. No further genetic testing is indicated.
56 I am concerned about the news report that stated the Pope advising
57 Catholics to abstain from all genetic neonatal procedure, (and I hope that the
58 translation from Polish into English was faulty). My consultant said she was glad
59 she didn't see the report on the recent TV newscast. By the way, [name withheld]
60 may have told you that the foetus his daughter is carrying has a severe anomaly
61 discovered on a mid-term ultrasound, and subsequent genetic testing showed a
62 Trisomy 13-15 defect with a terrible prognosis. They are aware. It is too late for an
63 abortion if they had wished for one. They are preparing themselves, and the church
64 they attend is supporting them with help and prayer.
65
66
67

1 Name: *Herbert E. Myers, M. D.*

2 Gender: *Male*

3 Age: *55*

4 City and Country of Residence: *Mount Joy, PA U.S.A.*

5 How many years are you a practising physician? *23*

6 Your medical specialisation? *Family practice 16 and psychiatry 7 years*

7 Name of your denomination? *Mennonite*

8 Are you actively involved in a local church? *Yes*

9 In what way are you active in your church? *Teach Sunday school, attend regularly,*
10 *infrequently preach*

11 I am willing to volunteer for an interview: (please state your full
12 address/phone/email for further contacts. *Yes*

14 **Issues at the Beginning of Life**

15 **Abortion - a situation**

17 I would first want to spend some time evaluating this most unfortunate and troubled
18 person. I would help her explore her life values including those that stem from her
19 faith. If she is willing, I may even engage another counsellor/therapist from her faith
20 tradition for additional help.

22 I would then help her look at the options in the light of her values so she can come to
23 a decision that she can live with. No matter what she decides I would not reject her
24 as a patient or person even if her choice conflicts with my own values. I would be
25 willing to care for her and help her go on with life.

27 I would be willing to give her advice as to where she can get the best care even if that
28 care is something I could or would not provide due to my specialty or values.

30 My approach may differ from other non-Anabaptist providers by focusing on and
31 valuing the individual rather than imposing my values on her situation and rejecting
32 her if she did not conform. I would also not push her toward a quick, easy fix that
33 she may later regret. Unfortunately in our current climate of quick care the ideal is
34 often difficult to achieve unless we are willing to forgo some reimbursement which I
35 hope my values would make me do.

38 **Issues at the End of Life**

39 **The Brophy Case**

41 I very much concur with the final decision to honour the wishes of Mr. Brophy and
42 his family. Though nutrition is a need common to all, providing it artificially is only
43 a convenience of our modern technology. This technology is a real gift to those who
44 have hope of recovery but is a curse on those who would die and never recover. Life
45 is a supreme value but not the supreme value. Life must be treasured and protected
46 but not preserved at all costs. There is a significant difference between actively
47 taking life and allowing death in a situation such as Mr. Brophy's.

48 Some especially of conservative faith traditions would differ with my opinion and
49 feel withdrawal of feeding is equivalent with killing though this is changing even in
50 such traditions.
51 Another value is stewardship of resources. To use limited resources to keep
52 someone alive who has no hope of recovery seems inconsistent with our belief in
53 stewardship. In addition this is often applied inequitably especially from a world
54 perspective but even in our wealthy, Western countries. In most countries, Mr.
55 Brophy would have died a long time before he did.
56
57 We live on the slippery slope whether we like it or not. Legalism denies this reality.
58 We must do the best we can with guiding values and principles and rest in God's
59 grace.
60

1 Name: *Dr. C. Janzen*

2 Gender: *Male*

3 Age: *33*

4 City and Country of Residence: *Chilliwack, British Columbia, Canada*

5 How many years are you a practising physician? *3*

6 Your medical specialisation? *Family Physician*

7 Name of your denomination? *Mennonite Brethren*

8 Are you actively involved in a local church? *Yes*

9 In what way are you active in your church? *Music, Children's programmes*

10 I am willing to volunteer for an interview: (please state your full address/phone/email
11 for further contacts) *Not sure at this time*

13 **Issues at the Beginning of Life**

14 **Abortion - a situation**

15 Before addressing this case, I would like to give you some background on my
16 particular locale of practice. I am a family physician working with university
17 students and resident physicians from the University of British Columbia. My
18 community is semi-rural, within a half-hour ambulance ride of several major tertiary
19 care hospitals. My practice includes obstetrics.

21 In British Columbia, abortion is a very available option for any woman. No
22 physician referral is required to acquire one, and it is completely legal and not
23 considered immoral by the population at large. As such, a physician is in no position
24 to prevent a patient from getting an abortion.

26 My first job in this situation would be to gather the basic facts. In other words, when
27 is the baby due, and at what stage is she now. This is important, because if the
28 gestation is beyond 18 weeks, no obstetrician would give her an abortion under any
29 circumstances.

30 Having said that, the social history given clearly leads to many non-medical issues. I
31 try as much as possible to limit my role in any patient's life to their medical situation
32 but I would ask her about issues such as her emotional state, whether she is suicidal
33 and so forth. If she has decided on an abortion, I would try to explore if she has
34 sought other options. If she is adamant, I would not try to stop her from having an
35 abortion. My personal views on abortion would not be made apparent to the patient
36 except in so far as I would not help her to expedite it. I would not try to stop her,
37 because I could not stop her and she would leave my practice. At least if I remain
38 her physician I can hopefully provide a touchstone whereby God may act in her life.
39 Some physicians I know would tell the patient that her desire to do this is immoral
40 and make it clear where they stand. This sort of medicine I have never tried to
41 practice.

43 **Issues at the End of Life**

44 **The Brophy Case**

46 This second case appears to be on the surface a difficult "euthanasia" case. Actually,
47 if the case is actually true as presented, it surprises me a great deal. In my situation
48 things would never go so far. In the first place, in Canada a "Hospital" as such is not

an entity which can decide on these issues. Only the attending physician for the patient can make treatment decisions.

The distinction between "chronically ill" and "terminally ill" here is interesting. The question as to what is a medical treatment vs. a "fundamental of comfort" is also interesting. It is considered very ethical and indeed moral to provide comfort measures to the terminally ill and to withdraw treatments which are not beneficial. The incurable cancer patient who cannot drink or eat is an easy case. Obviously providing nutrition and fluids prolongs the suffering of the patient who will soon be dead otherwise.

The difficulty arises in the patient who does not appear to have a disease which is killing him. In fact, the case of Brophy appears to show that his vegetative state is not a terminal illness and is not killing him. I would probably argue that the patient's inability to eat and drink would indeed kill him without artificial treatment and that to provide him with these things is the same as providing respiratory ventilation or cardiac pacing. I would not feel it immoral or sinful or unethical to withdraw artificial feeding methods. We know that the patient does not want these treatments and that his family does not want them. Even if I as a physician don't agree with what the patient wants, it is a well established principle in medicine and in law that the patient has the right to refuse treatment, even if such refusal may harm the patient. Even if the morality of the situation were not clear (which I think it is), the physician does not have the right to impose his or her values on the patient.

I think your question on whether other Anabaptists would agree on these questions is a good one. There is a tremendous dearth of teaching in the Church on these questions, because most theologians never have to grapple with the reality of these decisions. I have made many decisions to withdraw treatments like the second case, and I have made them in the absence of any direction from any other human being. Prayer alone has been my guide.

Dr. Carl Janzen, MD

[This response was send handwritten and by surface mail]

Case # 1

The decision is hers, but I would encourage her to think of the best interest of the child, conceived out of no fault of the child's. She has already made a lot of bad choices in her life, does she want to add yet another action to feel guilty about? I would encourage consideration of adoption- to consider action of the possible joy her gift could bring to an infertile couple. In summary, I would help her to be aware that she has several options besides that of aborting the child-options that might be in her best interest as well as that of the foetus.

This case is unclear. Line 4 is not a sentence. Is the pregnancy with the 'him' who 'befriended her', or with any of the four you raped her? Does she know for sure?

Presuming the later (4 men), if abortion can ever be justified, this would be such a case. If, in spite of my counsel to consider adoption, she is adamant in choosing abortion, I would tell her I would not (neither for reasons of consciences as well as lack of professional skill) perform it. I would refer her to a facility were she would be treated as a person, with respect. I would be saddened by her decision, but would not condemn her nor rupture our future doctor-patient relationship. I would walk with her through the trauma, but she would know clearly of my personal stance against abortion.

My non-Anabaptist colleagues are "all over the map" re. [a] stance on abortion. Their ethical consideration in some cases would be similar, in many cases different. I did a survey of Mennonite physicians 8 years ago. None performed abortions nor knew of any Anabaptist physicians who did. Most were not strident doctrinaire anti-abortion demonstrators, but were rather understanding of the painful dilemmas facing the woman with an unwanted pregnancy. Such a woman is in a situation with no "good" choices left, only the "less bad".

Case #2

I have spoken to Mrs. Brophy, and have heard her speak at several ethics conferences, so am familiar with this case, one of the landmark cases in the history of the modern bioethics movement.

I affirm Mrs. Brophy's decision and would have supported her in removing the feeding tube. Inappropriate treatment could be removing should be discontinued no matter when it is found to be inappropriate. Mrs. Brophy was the logical and legal decision maker and her wishes should have prevailed. Shame on the hospital for refusing to follow her directive and making her difficult decision even more difficult. Foreseeing death and intending death are two very different things. Allowing death and causing death are separated by a wide gulf, not the indistinguishable lines that the circuit courts in CA and NY tried to infer.

Brophy had already suffered "personal death", neo-cortical death, and should be allowed to complete his dying. To force his physiological body and keep his breathing when the person is gone, is coercive, violent, and obscene.

I know of no Anabaptist physician who disagrees with me, but there probably are some. Most evangelical bioethicists I know would also allow removal of the feeding tube. Only the most doctrinaire pro-lifers who care more for their absolute

48 doctrine than for suffering “patients” and their families would force this creature to
49 endure further prolongation of his dying process.

50
51 **Case #3**

52 I can’t intelligently respond to this case. No one around here knows what
53 TOP’s are. I checked with professors of bioethics at Michigan State also. They never
54 heard of TOP’s. What does it stand for? [Termination of Pregnancy]

55 In general, I take dim view of extreme reproductive technology and feel is
56 has gone much too far. Society doesn’t owe me a child. Children are gifts, not a right
57 that someone has to provide for me. The septuplet case is something for physicians to
58 be ashamed of, no proud of.

59 Simon and Claire should seek other ways of parenting or caring for a child-
60 not take the route that is very likely to bring another handicapped child into this
61 world. I don’t understand their thinking and motivation, nor would I respect any
62 physician who would encourage them. Their refusal to try IVF and donor gametes
63 should end the process.

1 Name: (optional) *Susan Harder*

2 Gender: *female*

3 Age: *30*

4 City and Country of Residence: *San Jose, California (temporarily in the U.S. from*
5 *Canada)*

6 How many years are you a practising physician? *I'm still in training; I just*
7 *completed my first year of residency. In 3-4 years I'll be finishing residency and*
8 *eligible to practise medicine independently.*

9 Your medical specialisation? *Anaesthesia*

10 Name of your denomination? *United Mennonite (General Conference*
11 *Mennonite)*

12 Are you actively involved in a local church? *No; when I was growing up in Toronto,*
13 *Canada, and living in Montreal, Canada during graduate school I was*
14 *active in the local churches there. However, since starting medical school and then*
15 *moving to the U.S. I have not been an active churchgoer.*

16 In what way are you active in your church? *See my response to the*
17 *previous question. I used to teach Sunday school to pre-school age*
18 *children, both in Toronto and Montreal.*

19 I am willing to volunteer for an interview: *Sorry, I cannot participate in an interview*
20 *due to time and geographical constraints.*

22 **The issues at the Beginning of Life**

23 **Abortion - a situation**

24
25 My response to this scenario would be to explain to this woman what her options are,
26 and then tell her that it's her decision (and hers alone) to make, keeping in mind her
27 present circumstances and her future prospects for change. Her options are as
28 follows: 1) terminate the pregnancy (although we're not told how many weeks she is
29 into the pregnancy, so her options for abortion within this scenario are unclear), 2)
30 carry the pregnancy and put the baby up for adoption when it's born, or 3) carry the
31 pregnancy to term and keep the baby herself. As a physician, I think my role would
32 be to lay these options before her, and help the woman think through them (weighing
33 the pros and cons), but I should not be telling her what she ought to do. There is
34 always a danger that during the discussion, the physician's bias will be revealed, but I
35 would try to refrain from letting my personal opinion of what I would do in her
36 situation influence her decision-making.

37
38 I don't think my approach to this patient is any different from that of my non-
39 Anabaptist colleagues. The ethical principle of patient autonomy dictates that we
40 provide patients with the knowledge they require to make informed choices.
41 Medically speaking, this is a young, healthy woman (except for the gastro-intestinal
42 illness, which sounds like it could be stress-related) who has successfully carried
43 three prior pregnancies. There is no medical contraindication to continuing her
44 current pregnancy. However, if the woman elects not to have a baby at this time for
45 personal or financial or social reasons, I would support her decision and refer her to
46 the appropriate clinic or hospital for an abortion.

Issues at the End of Life**The Brophy Case**

My reaction to this case is that I am appalled that it took this man's wife so many years to finally get permission to allow him to die in peace. I have not often come across patients such as Mr. Brophy who have so explicitly stated to their families what they would and would not want done in the event of an incapacitating illness. However, in cases where someone clearly expressed a desire NOT to be kept alive under hopeless circumstances for recovery, I think those wishes ought to be respected. At the point where Brophy's wife (acting as his substitute decision-maker) and all of his family members requested that artificial nutrition be withdrawn, the physicians should have complied with their request (again based on the principle of autonomy that I referred to in the first clinical scenario).

The argument brought forward by the New England Sinai Hospital, stating that they could not "in good conscience...participate in the discontinuation of artificial nutrition and hydration" is not a particularly good one. I have been taught during my medical training, and have recently re-read (in an editorial entitled "Substitute decision-making for cognitively impaired older people" by Margaret Brockett in the June 15/99 issue of the Canadian Medical Association Journal, pp. 1721-3) that "...when artificial nutrition and hydration are withheld or withdrawn patients do NOT (in italics, not capitals in the original text) have a painful death." (I admit that I have not gone back to look up the original research upon which this statement is based. Brockett herself makes reference to an article by J.C. Ahronheim entitled "Nutrition and hydration in the terminal patient" in *Clinical Geriatric Medicine* 1996; 12:379-91.) This indicates to me that the withdrawal of feeds from Mr. Brophy follows another set of important ethical principles: beneficence (doing good) and nonmaleficence (doing no harm). Since we know that Brophy did not want to be kept alive by artificial means, and since we know that withdrawing those artificial means will not cause him any additional suffering (although it will put him at risk of infections, such as the pneumonia that he eventually died from), it is completely justifiable for his physicians to remove the feeding tube.

Again in this scenario, I doubt that my views are much different from those of my non-Anabaptist colleagues. In situations similar to Mr. Brophy's, I have always been taught that it's up to the patient's next-of-kin (or other legally designated individual) to make medical decisions based on what they think the patient would have wanted. Interventions such as ventilators, feeding, hydration, dialysis, or antibiotics can either be maintained or withdrawn according to the substitute decision-maker's informed choices.

Genetic Counseling

I have not yet finished thinking about this additional question - I will reply to this at a later time!

Why did you become a physician, what was the underlying interest?

Well, good grades in science in highschool, the ability to do science in highschool and underlying all was a service motive, I wanted to do something to help people. It was a thing growing up that was very central. And on top of that was the influence of a teacher. A biology teacher who was extremely skilful, was named top teacher of the state of Ohio. He asked me to help him develop a manual for highschool biology, which gained a lot of usage throughout the state eventually. I liked chemistry, did not like physics, I loved history, so my love for humanities, and my interest in biology where constantly encouraged by my highschool biology teacher. It was also affirmed by my father who was a highschool principal.

I began thinking in those terms and move in sort of that direction when I was in CPS (civilian public service) during the second WW. I opted for alternative service, and part of my service, I was in three different locations. The third one was in a state hospital. One day, a man who was being discharged who was the morgue attendant, and he said 'I'm leaving, would you like to take this job'? Being interested in biology, medicine, I said 'sure, why not'. So I began as a morgue attendant at the [inaudible] State hospital in Michigan. So it was my task to open the body before the pathologist came. So this CPS man taught me how to open the body, how to open the sternum, take off the scalp. I tolerated that and became interested in that, saw for instance, the massive changes in the brain of syphilis patients. Back in 1946 about a third of the patients in mental hospital suffered from syphilis. So I saw a lot of the effects on brain tissue form syphilis. So when I came to college I just followed the pre Med track. But I also got into a lot of other stuff. I was being pushed by many people here at the college who said I should consider teaching. "Go get your PhD and come back here to teach", we need people in ministry like you, go to seminary come back here." But all of my interest in these fields, teaching or medicine, were predicated on being here (in Goshen). The night before I got on the train to Philadelphia to medical school, there were still people from my home congregation sitting in my living room, and pleading with me to come back. There was a crisis in my church and they were pleading with me to come back as pastor. I went to Philadelphia but once I got into medicine and experienced some of the fascinations and the rewards, I never looked back. My speaking skills have been utilised in many ways as a physician, so in many ways I have been ... so in many ways in the mid 70s on I was interested in the humanities to explore all through my practise, not only how we do things but why we do things.

And then in 1983 I took the Georgetown University Bioethics course, there was an Anabaptist teacher there, LeRoy Walters. So we had dinner at his home, and gradually, since 1983 I've been involved in bioethics ever since, I've been on the hospital ethics committee since 1984, since 1970 I've been chair of the Green Croft Foundation, a retirement community here, which is a long term care for the retirement community here in Goshen, and I just came back from a bioethics conference dealing with the problem of integrity in medicine. And actually I've been more interested in that than in molecular biology.

What kind of influence do you think AB theology played in your development and choice of career?

The AB ethic on peace and justice, I think many of the bioethical issues are peace and justice issues. In that way I got deeply involved in the health care reform debate in the Mennonite Church back in 1993-94. As Mennonites we were very involved in that issues in several major conferences on health care ethics and particularly distributive justice in the health care reform. So I think not only my experience as a consciences objector but also my service in

Vietnam, all the way through with MCC peace and justice have been major contributing factors. I remember one day when I was in medical school I got a phone call from the executive secretary of the Mennonite Board of Missions in Elkhart here, he was passing through. He was a much revered leader, J.D. Graber was his name, and he gave me a call and asked me "how are you doing? How are things going? You know, the church is really interested in how you are doing?" Boy that touched me. Here was this major leader who had an awful lot more to do than talk to this med student. He took the time and talked to me. One important thing for me is I always wanted my medical practice and my physician's attitude to be closely aligned with my faith experience. Now that hasn't always spelled out into distinguishing behaviours, I'm sure. I've been a Christian physician and probably you couldn't be able to define my behaviour from any other Christian physician. But every step of the way I'm Anabaptist, that's always there, if push comes to shove, being Mennonite is who I am. And my patients know that, there's no two ways about it.

I went to Chicago one year and did a residency in OB, cause I had to do a lot of OB here. And there I met a young nurse who eventually after graduation ended up as a nurse at Grace College, who ran the student health centre at Grace College 20 miles from here. She not only came to me for the delivery of her children but she invited me to her campus to do the premarital exams on her students at Grace College, because she preferred me over [against] the local evangelical physician. So there was something different that she recognised, wanted. So here I was invading this evangelical school as an Anabaptist.

Are there cases where you think your AB approach as a physician of justice, distributive justice and peace making is different from your average evangelical physician's approach?

I get lots of emails and information from the centre of bioethics and something at the Trinity College in Chicago, Val Killner and those people. The focus is almost entirely on abortion, that is about all they can talk about, and right now [Oct 1999] it's all about stem cell research. And I email back and say "this would carry an awful lot more weight if you would be equally concerned about capital punishment and war and justice. Your pro-life position is dramatically weakened by this approach. And I'm a little tired of the stem cell research and abortion. What about other bioethical issues?" Not that I want to do abortions, but I have seen cases where abortion is the least bad choice that a woman faces. I don't think it's ever a good choice, but it's never right. There are exceptions, but it is the least bad choice sometimes. I get so tired when all we talk about is abortion and stem cell research. And I try to make my voice heard that this is a narrow, truncated view of bioethics, let's talk about the whole field.

And evangelical Christian physicians were certainly very quiet on the health care reform in 1993-94. They didn't say anything, if they said anything, they were against health care reform, very much caught up in the economic, caught up in the economic and independent status of a physician and not willing to sacrifice any income for the greater good. I didn't see any of that. Whereas I felt so strong that when we were having an unjust system, we need to reform it. I personally would much rather deal with a government as a single payer for health care rather than HMO. I don't even know where they meet, at least I know where congress meets. Health care should be just, everybody is in the pool [of health care], and nobody is out. That to me is a priority and it beats out the priority of the disadvantaging of a bureaucracy against the poor. So I get tired of evangelical physicians.

89 **So would you say that mainline evangelical physicians walk too narrow a line which is not**
90 **enough influenced by their theology or is it that they are so overloaded with work that all**
91 **they can think about is abortion and stem cell therapy?**

92 Its not that they're overloaded, its their focus which is on that and it is tunnelled
93 thinking and so it becomes their cause to operate. And I don't think they look at the care of the
94 poor in the same as that they look at abortion. Abortion is much more a hot issue for them, and I
95 think that the care of the poor and justice in health care should be way up there on the agenda.
96 But they are absent in the agenda and I don't even go to a lot of their meetings because it is
97 under the umbrella of conservative evangelicalism. It's a culture of its own, and I'm not part of
98 that culture, I'm an Anabaptist. **It's this Anabaptist counter culture thing again, right?** Right.

99 **Can you think of any other issues where you would not see with them eye to eye, besides**
100 **abortion and stem cell research?**

101 I hate to bring up these issues cause I haven't done enough thinking about it, but I think
102 there is a major gap between 'intending death' and 'allowing death'. For me that is a great one
103 but I realise for many people it's a minor problem. So it's the courts who tries to make a
104 decision. And yet, as in abortion there may be [inaudible] And I am not saying there are cases
105 where it's difficult to differentiate between adequate working of terminal sedation vs.
106 euthanasia. There is no such thing as a 'yeah lets do it', but I still think there is [inaudible], I
107 have seen physicians suffer a lot from this question but I hate to see to get it legalised when
108 each one can choose to die.

109 **How do you define the difference between 'allowing to die' and euthanasia?**

110 Well I think intention is a really important issue, what is intended to and what isn't,
111 when one terminates life or when one removes the feeding tube and says "this has gone on long
112 enough," and when one chooses the moment of death are two different things. I'm not sure I'm
113 keeping faith with the patient when he dies, and I don't want the patient or the family to think
114 that I would ever cause a death. They will also know that I will not needlessly prolong suffering,
115 and I leave that to God and I get out of the way. And I believe we play God just as much when
116 we needlessly keep adding more and more and more intervention. Playing God is not part of my
117 duty, that's nonsense. And my getting out of the way and having a natural process is the humane
118 and the good thing to do. Especially when I think of the millions of this world who don't ...the
119 advanced directives which have never caught on in the minority communities. If we for instance
120 take the native American community, they sign advanced directives even inspite of the fact that
121 the Federal Patient Self Determination Act requires the hospital to approach this subject with
122 everyone who enters its doors. Only 15 % take advantage of that act, and with minority groups
123 particularly. They spend a lifetime trying to get into the system, why would they opt out all of a
124 sudden? When you take a world view which doesn't make sense, of prolonging the lives of
125 critically ill aged people.

126 So I have been active in the writing about the prolongation of needles suffering, and a strong
127 advocate of adequate pain management. I wrote an article on the Medical Messenger about a
128 year ago, where I strongly favour the adequate use of pain management. I think we do a lousy
129 job.[It] usually [happens] at viewings, and if you are a person of my age you go to a lot of
130 viewings, "oh I'm so glad that Mom is out of her suffering, she suffered so much." She was in
131 pain? Come on! There is this ridiculous notion about addiction in pain relief. So, that is another
132 issue.

The questions which come with new medical technology, are those dividing lines again between those who can and have and those who can't and cannot have?

I think yes. A lot of the issues that we discussed this weekend had to do with managed care, managed care will NEVER bring insurance for the poor or the millions of uninsured. The market is useless to give it universal access. So there is whole discussion how we can treat people and keep our integrity with managed care in the face of the corporatisation of medicine. Nothing [is being done] about the 44 million who have no managed care or anything else. So that's always there and is I think the obscenity of our system.

What would be a unique AB medical ethics, if there can be such a thing, and should there be such a thing?

Is there anything in AB theology that would remind us of what the total picture is, which would include that everybody is in, nobody out? Is there a picture where we see cases of abortion or stem cell research in terms of the total world and the total human race? I'm not sure we're unique, I know there're other Christians who are thinking these thoughts, but one of our things is that we tend not to be absolutist and doctrinaire. We look at the individual. I don't know that I'm accurate enough, but this is the way I look at it and I have always been Anabaptist. The reality of being a doctrinaire and an abortionist, or a doctrinaire and a stem cell research person, is to recognise that life is a slippery slope. Everyday of our lives we are on that slippery slope, making decisions, depending on the circumstances, trying to be led by the Holy Spirit, and make decisions as we understand God's will.

Abortion is wrong, I don't give a hoot whether you became pregnant through incest or rape or whatever, abortion is wrong. I don't know whether its AB or not, but that's where I am. But there might be cases where abortion is the least painful path. To look at all those issues in terms of their broader justice implications, whenever you do something or some individual, whenever I suggest something to somebody, when I suggest bypass surgery to an 85 year old, that money is not going to go to something else. We are always rationalists, and now we are rationalising pocket book control and insurance coverage. In one way or another, directly or indirectly, what is bound on just procedure, that money will not be spend on unjust kinds of things. Immunisation, prenatal care, instead of IVF and having seven kids who eat up all the resources [refers to the septuplets]. To me, that is unjust and I'm not the only one who is mad about that case, who feel this just doesn't make sense. I don't know is this theological or not, to me that is a misuses of resources and that I should be willing to sacrifice for that purpose.

And I hope that when I reach the fullness of my life, when my autobiography has been written, that I would choose to opt out of that kind of expensive intervention when so many needs are crying out to be met. The problem is, in Canada you can do that, and money would go to that [cause specified by the patient], but in this country with this system, my declining open heart surgery at the age of 90 doesn't mean that that money would go to the most pressing needs. That is unjust and I think it is a great failure of the Anabaptist community that we are not on the front lines of health care reform and crying out about the injustice of this issue. That for me is a bioethical issue to step in when injustice is there. Oh we have a statement on the book but you can't get church leaders to do anything about it because we are so consumed with homosexuality.

What do you think then should be changing in the AB constituency to make the issue more important or more heard or does it have to be again the case that so and so many things have to happen in the church before somebody actually really talks about it?

Pilot Study Interview # 1

v

I suppose the latter will happen, something will have to happen. I don't know how we can get the conversation going, I supposed to write an article in the church press, and I've been meaning to write that article for three years now. But we did write to the general secretary of both the MC and GC church, and pointed out that there is nobody now who is caring for the concern for health in the church. Health has been dropped as a concern. [A]fter the demise of the current health care reform, we had a Mennonite Health Forum established, which was to carry forward the churches health agenda for the years to come. Two members of that health forum are Mennonite Mutual Aid and MHS and when we scheduled our forum meetings, neither of them even came. One is an insurance company, one is a health care administration, they're busy on their agenda; the churches agenda in general isn't health or health care, nobody is caring except for saving souls. How we get that structure revised is going to take you guys [me??] to revisit it. You are in a place where the structures are, you will gonna have to give health a hub. The MMA and MNA all signed on to that letter and we posted it 1 ½ years ago, but [pause], so, agitation, letter writing, continued work,

How about teaching on college campuses, you've said that earlier, that its not a part of the curriculum. Would that change anything?

We tried to get administration to add a course. We had an awful time trying to get a bioethics course on campus, and even now the course is largely attended by nurses. Nurses are much more interested in ethics than pre-med students. And the premed faculty doesn't even recognise bioethics, how can you get them to put bioethics on the required curriculum? "We already have too many requirements..."

What would it take to convince people that this is an important issue?

Somebody with power and authority over them has to make them put it in the curriculum. I can already see a groundswat of excuses, [I'm] thinking that the demand can either come from below or above. But I can't see it coming from below, from self-satisfied Mennonites who have health insurance. I don't see it coming from med students who are consumed with grades and getting into med school. I often do breakfast sessions to med seniors, few came and they did appreciate it when we talked about ethical issues in medicine, but most of them are too busy. Whenever we had it there was a bunch of excuses. The pre med curriculum is so full with science courses, the requirements to get in; its the consuming passion to get into school, they don't have time to think about what they are getting into. And the way in which this system is gonna co-opt them is [inaudible] because that system is going to eat them up and all of their idealism will be ground into pieces, and when they get there they will see that medicine is a culture of its own too. It sure changes the unwary. And it discourages me to see so many Mennonite physicians coming out of medical school who look just like everybody else, who have no concept of a unique calling. What does it mean to be a physician, why am I here, what is the larger goal of my life, what am I doing here other than deciding on a pill?

If you were to write a unique, Anabaptist focussed, Medical ethics curriculum, what would you put in there?

220 Wow. I haven't thought about that enough to give you an intelligent answer. As an
221 Anabaptist I have my thoughts about things, but...

222 Oh I would examine what is the meaning of life, the meaning of death. What is the
223 mission of medicine really? What are the limits of medicine should be in that. What about this
224 term that is still around, the talk about the sanctity of life? The value of life as I read it in the
225 bible is captured by life lived in relationship, life in relationship to God, to my neighbour and to
226 myself. Life in relationship; the meaning [of life] when I have lost all human capacity to ever
227 relate again to another human being? I don't think then one should stay on. Maybe my being
228 there will bless my caretaker, but that life has no meaning for what you get out of life. So, when
229 I have lost all of the human markers, and when the only thing I still have is only physiological
230 existence that we share with the animals, if that's all I have, is that human existence? But I'm
231 not sure its being alive. I'm certainly staying out of the way, I'm not gonna kill them, but I'm
232 sure not gonna sustain them either. So those issues, the meaning of life, the meaning of death. If
233 you are a physician in the ICU and somebody's potassium level goes down, of course you
234 correct that potassium deficiency. It doesn't matter what the patient wants or the family wants or
235 what he circumstance is. And all you do is prolonging existence, I would be crying out. I don't
236 know is it Anabaptist or is it just a Christian view. My parents did have to face it, we didn't
237 have a choice, people died.

238 I guess an underlying Anabaptist concept of community vs. the individual, where in
239 some situations I as the individual have to give up for those you are worse off than I am. Just
240 this weekend, this physician described that story of a patient of his who could not afford, he had
241 diabetes, and gangrene on his extremities, he had heart failure, was hypertensive, an acute
242 medical crisis. And he could not afford the drugs necessary to treat his conditions and he died.
243 And the physician, as he reflected on this case asked: "What should I have done? Should I have
244 bought the drugs for him out of my pocket? Should I give up 25% of my salary to buy drugs for
245 my patients? 25% or what about 50%, what's the limit of what I should give up for the sake of
246 these people who are dying because they can't afford drugs?" That guy is asking an Anabaptist
247 questions although he is not an Anabaptist.

248 Well, thank you so much for your time.

How did you decide to become a physician?

I decided in highschool to become a physician. When I was in highschool, I really became interested in biology, really loved it a lot, and at that time as a Mennonite Christian, we didn't think much, and I guess weren't encouraged to become a biologist or a chemist. You usually went into a service profession, either teacher or medicine. And I also knew some people who were physicians, and admired them, I guess thinking about biology and how can I use it, well I didn't feel any interest in teaching biology but became interested in medicine and started pursuing it and pretty much stayed on that track then through college. The only other thing that almost got me off track was I thought of going to seminary, especially when I got a D in calculus in my first year in college. Then I thought God was calling me to seminary. Fortunately the student pastor at school said "do you really think that this is the way God calls you?" Well, he also wondered how I got the D, you try another semester and do well and see how you do. Well, I did well and stayed in medicine. So I think I majored in science and then also the tendency to go into more service professions

What kind of influence do you think your Anabaptist upbringing had in that, other than prompting into service projects, any other influences you think of?

Of course the whole emphasis of peace and service, we weren't going to go into military but instead doing some sort of service. I was familiar with people who had done some sort of service in the health professions, in fact I eventually did go and do my I-W service in Puerto Rico after I was part way through my family practice residency. So I think the whole thing of wanting to be of service for the church as well as people in general and not doing that service through military service. It was a natural out growth of that, the belief of caring for the body of your own as well as other peoples, the body of Christ which is in some sense everyone, I think, influenced me also wanting to be part of healing.

I'm not completely sure where it [medicine] came from cause in my family there was no one in the healing professions. My father was a farmer, my mother was a farmer's wife, and I was the first one of my cousins to go into anything like that. Now I have a couple of uncles who went into the ministry, but not much into health professions. It didn't come from anyone in my family. My wife's father was a physician, and we started dating when we were in high school, so this may have had some influence, I had contact with her family and what he did as a general practitioner. But as far as the Anabaptism itself, there was a strong emphasis on service to God and people, and on people who pointed in that direction. When I was growing up lots of people went into the military service, you know but to me healing was something I always admired. I used to read a lot, I used to be a reader, I still am, and I read all those missionary stories and there was a time when I probably thought I would be a missionary doctor. Didn't really do that over there, a short term in Puerto Rico, I was in Honduras for a couple of week with the CMDS short term mission, in fact I didn't even take over my father-in-law's practice in West Virginia, when I graduated because we were good friends but

practising with him would have probably not stayed good friends. In fact we practised 8 years in Mississippi in an inner city clinic after my original group practise here in Pennsylvania. That was a service in an underserved area.

You said in your reposes that you're specialised in psychiatry and are working as a psychiatrist now, how did that come about? Was it a natural progression of specialisation or particular interest

It was of particular interest. I was in practise here in this community for 6 years in family practise, and the group I was part of had the option of taking a year sabbatical every 7th year. So in my 7th year we went to Mississippi for a year, and I ended up staying for 8 years at that inner city clinic. One of the ministries we had was to the chronically mentally ill. We had a contract with the county mental health centre that we did all the medical care for their clients. So when they would be admitted to the hospital, they would have medical problems, I would see them in health management, but then a lot of them came to our health centre for medical care. And a lot of personal care homes where I was kind of the doctor for their homes, I either got to the homes or had them come to our clinic to see them. I really got interested in the mentally ill. First of all, a lot of them seem to be the more sick they got the more religious they became, they'd think they were Jesus Christ, so that was fascinating. It was a little frustrating in family practice just because of the high volume of seeing people fast, I really wanted to have more time to talk to these people.

And so I began thinking psychiatry, I liked psychiatry in medical school. My wife said it was more a mid-life crisis than anything, to understand myself. But I enjoyed those people. After seeing somebody in the office for almost 2 years, and they look at you and suddenly say hello to you- that is just so rewarding. I really liked to learn how to be able to deal with those people better. Plus, not only the chronically ill, but the people suffering from depression, when you pick up the chart at four in the afternoon and you're tired and you tick depression. Well you had 10 minutes maybe to see the person and you are already behind schedule and so you'd write a prescription for an anti depressant but you really didn't feel you get to the root of the problem. I think it was some of those big questions that kind of made me decide the change to focus more on the mental. But I was always interested in the integration of the physical, the spiritual and the mental. And somehow psychiatry seem to allow me to have some time get into those things.

You said, the more ill people got the more religious they got? Is that a pathological thing you discovered, or is it more a person to person difference?

It's more a person to person thing. People get delusional and many times their delusion are of a religious nature, and when they're cured it goes away and they're not necessarily religious at all. But I don't have all the answers for it. I think its probably part of the culture. One of my professors here at Hershey was from Iran, and the same thing happens in Iran, except they don't think they're Jesus, you think you're Mohammed or someone else. So it must be a cultural phenomenon It's an important part of our life growing up and you become ill [and] it gets distorted.

Do you think your personal approach to your medical practice or to your work is different from another doctor of a different faith or no faith approach at all?

I would think so. First of all my faith motivates me to be as good a physician as I can be, to be as competent [as possible]. I heard the question 'would you rather have an incompetent Christian physician or a competent non-Christian physician?' Oh, I would pick the non-Christian who is competent. But as a Christian my first responsibility is to be good physician, to know as much as I can in all the areas and to apply that. When it comes down to how does my faith impact and how would that be different from other Christian physicians, I think the way I would see myself as a witness probably is different in that I don't necessarily see my job as winning a soul in the traditional sense, whatever that magical thing means. But really winning the soul and trying to help the life change towards what we were created or intended to be, which is once again ministering to the whole person. I think a lot of that comes out of the Anabaptist caring, and that we are not the traditional evangelical Christians, where evangelism is the primary thing. When I think of MCC, we went abroad and try to minister to hungry, to health needs, to teaching needs, and its kind of through that that the gospel is attractive to people and through that they may change their lives, and that they may be better people to their communities. So I guess I would see that as being different, and I really try to help people to be whole, not just be saved from their sins.

What do you think are the specifics that distinguish you as an Anabaptist medical doctor from a Pentecostal or Baptist medical doctor? Are there areas where you would say there is a difference or is that too far fetched?

I think it's a bit far fetched, and I think every person is different, so you might get one answer from an Anabaptist and I don't want to put all Pentecostal doctors in a box. But you know, I am not necessarily bent towards praying for dramatic healing but the struggle for a person to live and be a whole person and to find maybe our peace witness. I think that's where the peace witness comes in, to find wholeness and health and healing in our lives. And of course that is a struggle for me cause I'm a compulsive person and I like to cure people and I miss now treating a strap throat where I know when I give them penicillin then they get better. But helping people to move towards wholeness even if it doesn't mean cure; when I worked in a state hospital just having someone with schizophrenia become able to interact in a better way with other people, reduce their paranoia, and increase trust, even if there was a little bit I saw that somehow fulfilling a mission for making people whole and to have inner peace rather than being just being saved. I guess somehow I think it is a bit more holistic.

If you think back over the cases I've send you how would you say your approach as a doctor influenced by your theology, how would that approach differ from a doctor who doesn't have a faith perspective?

Getting older, I'm not quite sure if some of it is ageing or some of it is also faith, but I tend to be little less legalistic, probably years ago I would have had more clear answers in those cases, you know the highest rule is you don't abort, period, there is nothing to talk about. Whereas you know, particularly in my situation in Mississippi, really getting to struggle with people who are poor, people are subject to a lot of the evil of our society, you're a little less easy to say there is only one way in God's eyes to do things, and you better do things or else. But walking with people, so if the woman finally comes to say you know "I really need to abort this pregnancy", then I would walk with her. I might feel uncomfortable doing an abortion myself, I'd probably would, I don't think I could do it, I certainly would not reject a person who chose that. The person who chose that, I would point them [a] way to go to find a safe place to get it done, and then would welcome them to come back and continue to walk with me. I remember that when I was in family practice here in Elizabetown, we had a lot of women from the college, Elizabethtown College come to our office with unwanted pregnancies. Well, you know, what do you do? Do you say, "well, no, you shouldn't abort that"? And of course bottom line they knew exactly what they wanted, they wanted us to confirm the pregnancy, and give them a referral. I usually would try to talk with them about adopting options, tell them where they can go for abortions, well of course, most of them knew that, but welcome them to come back and continue the journey of preventing this from happening that in the future. And looking at what that meant for their lives, some of them of course would have the abortions and that was it, they were on. But there would be others, maybe because of their faith background would struggle with guilt, well, I think we need to struggle with them in their pain. Because you know, I have my sins, they have their sins and we need to struggle together as fellow pilgrims.

It is sort of the same way with end of life issues. Of course now I primarily work in geriatrics psychiatry, and [I'm] doing nursing home consultations. Now I see all these people who want to die, and in many ways we keep them alive and prolong their life. And it seems that God and they and nature want to die but we don't let them. Well, I'm still not ready to take their lives, but I think we would do a whole lot better walking with them in the dying process and talking about the dying and all that stuff rather than treat all these illnesses they have to make them better which doesn't do much other than maybe prolong their suffering. So you know I personally have no problem with helping family if they decided one of a loved one who had almost no chances of recovery to turn off the ventilator. I'd probably want to stay and do it with them but make them do it? But you engage with people in these life struggles and that is so critical. I think too many times as Christians we kind of get answers that are black and white from scriptures. I don't see that in scriptures at all, I see Jesus, God struggling with people who're making dumb decisions. I think about it in the OT when Israel wanted a king, and God said "no, I'm to be your king, why do you want a king"? And that kind of struggle.

We have a daughter who is homosexual and maybe some of these life experiences change us too, you know. There would have been a time when I was completely ignorant about it, but you had to put it in your face, it helps you as you relate to people in your practice and maybe changes a bit the way you practise. Because of life experiences, they're also causing you to re-look at the bible and was I really reading it correctly to what I thought it was saying about one way to do things. When you think it is saying one thing and then you see people struggle with others. No it's not an easy issue.

If there is such a thing, what do you think an Anabaptist Medical ethics looks like, or a medical ethics based on Anabaptist principles look like?

I would like to think whether we have an Anabaptist ethic, that's somehow based on Anabaptist faith, because faith is an important part of life, it needs to at least influence ethics and try to frame it a bit. Again the whole belief in shalom, in peace, I think needs to somehow play in how we practice. Its not just about not going to war, its helping people to be whole, it is more of a justice, as Anabaptist/Mennonites its more of a just salvation. Its helping people to be the most they can be in the condition they're in, physically, mentally, emotionally and spiritually, about ministering to the whole person. And I think in some ways our view of salvation is a bit different than other groups, in that it does involve that. That's why I think the Mennonite churches had MCC, not just a mission agency that goes out and saves souls. So I think that translates into our medical practices, where also for example I have a hard time seeing were someone who comes from an AB perspective can go into medicine just for money, or just for personal satisfaction. I think there is this whole thing of serving God, the church and the community that is behind what we do, so the money we make, sure all want to make enough to live, but that's secondary. I struggle with that, I work for a Mennonite hospital, I've been involved with over the last year, and of course they struggle to make a go of it in the managed care setting. I think we keep struggling, we just had a vision conference on how do we continue to serve the indigent population but remain solvent as an institution economically, and I think especially as Christians with an Anabaptist perspective we MUST be willing to serve those who don't have services from other sources.

So again, poor people, disadvantaged people?

Poor people, disadvantaged people, the dying and in my work right now at a nursing home. Half of the people I see are demented. People say "how do you do that?" Well, when I think about it, part of it is because they are still human beings, and I don't know what's going on inside them, but they need to be treated kindly and I hope I can influence the nursing home to treat these people kindly to make their dying as good as it can be and to make the rest of their life as good as can be. And I think, you know, we as Anabaptists have always respected the bible and I think that makes me also want to minister not just to the minds or to the body but also to the soul, to at least give them an opportunity to talk about faith. God, what does God mean to them in this time of their living and dying. If they don't want to talk about it that's OK, I'm not going to force it

on them but there are a lot of people, especially I find it in the elderly, they are very glad to talk about it. Faith issues, questions they still struggle with, what does it mean now, that I'm dying in this way.

I had recently two patients, both were elderly men, both with a lot of physical problems. One of them was so dejected, "why do these things happen to me, I was in WW II (this is a real challenge for me as a pacifist), he was saying how he was in a death march in the Philippines, and he was the only one who survived in his regiment. As the Japanese killed them all, the gun miss fired and he fell over and pretended he was dead and then he got away. Then his landing craft at Hiroshima was sunk after they landed, so he was at sea for 30 days and so he says "I survived it all this stuff. And now I have an auto accident with my wife who is demented and I was caring for and now she is stuck in a nursing home. Why, why, why?" Then there is another guy who was a pastor, an elderly man, who had the same problems but he was just rejoicing in life. See, how can we help those two people to continue to be fulfilled at the end of life even with a lot of those disruptions? Walking with people.

And again, I don't want to distinguish us completely from people of other faiths, because I know a lot of other Christian physicians who do much the same thing. But I think it is part of our Anabaptist position, maybe that is why we have our own Medical association, because we do see some differences that make us different. I was a member of both CMDS and MMA, but I'm no longer a member of CMDS, and I often felt a lot of their ethical positions were a bit more legalistic than I was comfortable with.

In what way? Well, abortion, we don't support abortion. And yes, there is part of me that says I don't believe in abortion either, for example, as a method of birth control. I get very upset when I hear people choosing the sex of the baby, those are kind of ethical issues. And yet if a woman is caught in a situation where she is pregnant, whether she goofed that up or she was raped or whatever, I'm not ready to condemn her to hell because she chooses to have an abortion. But again, I think that thing of walking with people, guiding rather than judging. CMS, too fundamentalist, too rigid, and again I wouldn't want to say this of all of them, because I know some people in the CMDS who won't do abortions, they would very strongly counsel against it, but they still would walk with the person. But then there are others they won't, once the person makes that decision, than you might as well go find another doctor. I have trouble doing that. And also the tendency, the ultimate thing we can do is win someone's soul, now to me that needs to be more holistic than just that magical thing to just accepting Jesus' blood as washing away their sins. It's more like accepting Jesus way of living so that we can live better on earth, and minister to each other more. They wrestle with things, but they're still not, well, maybe my faith is getting too shaky, but there's got to be that right, final answer underneath and they decide they have it.

Do you see that a personal progression? Like we can't totally know to the point 'this is right' and 'this is wrong', or is it more an Anabaptist thing that we need to know what's perfect but we have to be realistic in what we can do or not as people?

And maybe too, it's a little bit different to in a way at least some of us Anabaptist approach scripture. I think for some groups 'the bible says it and that's the way it is'. As Anabaptist, at least the way I grew up and at least the way I was taught, I went to Mennonite high school and college, was to look at scripture, wrestle with scripture in the community of faith. It's a guide but we always interpret it, and you may interpret it one way and I interpret it another way, and that's a constant thing that's in flux. We just have that in our church, we have a group in our congregation who tend to follow the more right wing, conservative, fundamentalist Christian leaders in our community, and another group who wants to be Anabaptist. So the one group says 'Paul says a woman is not to speak in the church so we can't have a woman in the pulpit.' And I say, 'well yes he said that into a culture of his times, and now how do we work at that now in our day, in our community of faith, when Paul also says in the ultimate community of faith we will all be one, its not going to matter what our gender or nationality is. I guess in my experience at least, a lot of the Anabaptists have more allowed scripture to be wrestled with in the community of faith. But it doesn't stand up here as rulebook.

If there is a difference in Anabaptist medical ethics, what would you put into the curriculum for medical ethics?

Well, as I think about it I would certainly want to have some segment on how does faith impact or help determine our ethics? How does the community of faith help us wrestle with ethical issues? And then I think looking especially at our Anabaptist background how does our belief in peace impact our ethics and the way we live? How does our faith in peace impact the way we live? How we live our faith is as important as what we believe [and how it] impacts our ethics. And I think going then into specific issues, beginning of life, end of life, genetics I guess is getting to be a big one, you have to hit on all those specific areas. And then as a class maybe be wrestling with those issues, see here is our basic beliefs, how do they impact these medical ethics issues.

Once we get into practice, what community do we have? Because I don't think in a course you won't have a cut and dry answers to every issue, what community do you set into place in your own community where you continue to wrestle with. Be that a Mennonite medical group chapter, or a group in your church, or whatever, that you wrestle with those issues together. A lot of people don't like Fletcher and his situation ethics, but there is a lot of stuff I like about it, for he is really honest. Every situation is different and it is hard to make laws that apply to every single situation. We need a community in which to wrestle with those issues. That's what I like about being back in a Mennonite institution, where we can wrestle with it from a faith perspective. Where do we want to be in 2001 as a Mennonite Psychiatric hospital? What will make us different in 2010 from the other hospitals around who offer psychiatric care? Are we really different or does managed care force us into this mould where we have to see patients every 10 minutes and the psychiatrist can only do med checks and doesn't have time to ask the person how they're doing, and spend some time.

And payment is an issue. Are we willing to make less to do some of the things we believe are important? Medical economics is an important thing you want to have in

288 a class. How does the market place drive the way we practice? We need to say
289 something about that, it is becoming a bigger issue, at least I know it is for me. As you
290 get managed care that says all you get is three sessions. Well what if the patient needs
291 six or ten? Do I say no, I don't do it? Or does my ethics say, I stay with you, I will charge
292 you less? I don't know. Those are pretty important issues, to understand how the market
293 determines the profits. And I think our faith is one thing that has an impact on that.

294 In the clinic that I was with in Mississippi, basically, we practised in an inner
295 city black community and in addition to the mentally ill I talked about before, we had a
296 lot of single women coming in with either pregnancies or wanting contraception. Well,
297 we did prenatal care, I didn't do deliveries, but we did prenatal care and then referred
298 them for delivery, that was no problem, but 'Words of Calvary Ministries' that I worked
299 with tended to be more in the evangelical, fairly conservative camp, even though it was
300 black run. The biggest struggle was, what about these single women who are single but
301 are sexually active? Well there were some of the people who had come there to work
302 said, well you tell them to be abstinent, that's our responsibility as Christians in health
303 care. Because the bible says unless you're married you can't have sex. Well, OK. That's
304 one approach, you know. I wasn't comfortable with that, and said 'you know, would like
305 to struggle with these women and give them choices'. Well that was OK for most people
306 but the biggest struggle was with the IUD, because some of the staff said 'I won't help
307 you put in an IUD because that's actually causing an abortion, because it keeps an egg
308 that's fertilised from being implanted.' I'm not sure, just as you were talking I began
309 thinking about it, was it my approach because I'm liberal or was it my approach because
310 I was Anabaptist? I'm still not quite sure, but I think it hard to think the God as I grew
311 up knowing, to care as much about these couple souls that are floating through space
312 before they implant as God might care about this woman who had no modelling for
313 being a mother in a two parent family, because probably her mother was slaving away.
314 But they think of it part of growing up was trying to go into a culture and trying to
315 understand a culture and where people come from. And that isn't what determines our
316 ethics but it maybe determines how we walk alongside people, giving them time to come
317 to the point where I am now because of [how] I differ – if that's a good place to be at.
318 So, personally I didn't have as much trouble putting in the IUD as a number of the
319 people who worked with me. But there again, their basic approach to scripture was 'here
320 are those verses and that's all', rather than wrestling with people and their life issues and
321 all the justice issues that are involved in that as well. That really impacts where I chose
322 to practice, and how I chose to practise with [the] people I practise.

323 The state hospital, well, of course the state is trying to get out of health care, so
324 the state wanted to downsize. And of course the rumours are "close the hospital." Well
325 how do we deal with the people who have been in the state hospital for years, and not
326 just kick them out in the streets or they end up in the streets or in prison, but as Christian
327 I thought it was my responsibility to try to help to influence that. In fact, the last place I
328 worked in a hospital, was a ward for elderly women, and the state was saying, 'none of
329 these women belong into this State hospital, get them out.' Well, I could have just tried
330 to discharge them into nursing homes, except I know some of them didn't want to leave,

331 some of them were to sick and unstable to be in any nursing home I knew existed. So I
332 think probably because of my faith I started to raise questions about the system. Well
333 when you butt the state, I just kind of burned out, that was one of the reasons I changed.
334 In fact, I was appointed to a state committee about the question 'what are we going to do
335 with the elderly in nursing homes'? At the hearings in Harrisburg, PA, there were the
336 people from Pennsylvania Protection and Advocacy, which is a federally mandated
337 watch dog group who go into mental institutions. I guess they go to others too, and be
338 sure that patients are well taken care of, they're not being abused and all this stuff. So
339 they had this meeting at the state hospital say we have to get rid of them (the old people)
340 , so when I would raise the question 'look, you are advocating for these patients, there
341 are these patients who don't want to leave the hospital, their families don't want them to
342 leave, can't we just not discharge them? They're going to die in the next 10 years, can't
343 we care for them in the environment where they have lived, and then let them die and
344 maybe don't admit new ones and make places in the community for those for whom
345 that's possible'? Oh now we need to have them in the community, and they would
346 describe cases that would not even exist and at this point nobody is going to pay for [it].
347 It's like butting your head against the wall and the only thing that would hurt was your
348 head, but still, I believe we still need to be advocates. I think that's what gets us out of
349 the office into the street, to be advocating for those who maybe can't advocate for
350 themselves.

351 When I think when I was in Mississippi, we tried to see that our patients we
352 couldn't care for, we would get consultants that would care for them well despite maybe
353 even only having medical assistance or maybe no medical insurance. So you know if I
354 had a cardiologist who would treat my patients mean I would not again refer them. We
355 developed a list of consultants who would care for our black poor folks just as good as
356 they would care for anybody else, as much as we could do that. I guess that's the
357 advocacy part of it. Maybe that's also part of our faith heritage; well some people would
358 say your faith belongs into the church it shouldn't be out in the political sphere. Well, I
359 think as Anabaptists we tend to say 'no, we do speak to government, we do speak for
360 justice for all' and that's another role, and probably in health care we need to do the
361 same thing. I think it's wrong that we have a wonderful Medicare system but it doesn't
362 pay for the medications for the elderly. I support Clinton on that one, somehow we need
363 to find a way for those people to afford their medication. I often tell my patients that
364 some of the newer drugs we have in psychiatry which are wonderful, they are as
365 effective as the older drugs with much less side effects, but the only side effect is they
366 make you poor. You either have to be real poor so you are on medical assistance and the
367 government will pay for it, or else wealthy, but in the middle you can't afford them for
368 long term. I think those are issues we as Christians also need to be speaking to.

369 So as part of that ethics course I want to have something on advocacy as well.
370 Part of our role is to speak to the powers that determine what happens to the little people
371 in society. Hopefully we are setting a model of caring for [them] in our practice. If I'm
372 not taking Medicaid patience in my practice, I probably have not right to tell the
373 government how they ought to treat these people. I hesitate to say that this is just a faith

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374 heritage, but it is following Jesus and do as Jesus did. So we can not only advocate to
375 government but also advocate to other faiths, because some people look at our faith as a
376 model in the area of service. And I think in health care, we've been known to have, we
377 don't have many general hospitals anymore as Mennonites, and the psychiatric hospitals
378 are kind of getting fewer, but you know our history of caring for these people came out
379 of our resistance of going to war. So the government assigned us to these mental
380 hospitals for two years, but our CPS people saw what was wrong there and we have the
381 Mennonite Mental Health story. Those who came out of there saw what was wrong and
382 they either started to change some of those institutions or started some of our own in the
383 church.

384 Well, thank you very much for your time.

Interview # 1: taped 18/06/2000 (tape malfunctioned, interview was kindly emailed by the respondent)

Dr. Michael Massanari

> Internal Medicine, infectious diseases, Epidemiology

> Professor of Medicine at Wayne State University,

> personal interest: justice, access to health care,

1. Reflections on teachings of the church, experiences, and career choice.

- Based on my personal reflections as well as observations of my parents, I discussed being a physician as early as age 4 or 5. Although there were other possibilities, this choice was always a top priority. I suspect my early interest was heavily influenced by family discussions about [medicine] and with an uncle who was in medical school at the time, and an aunt who was a nurse. Since my uncle and aunt both grew up in the Mennonite Church, I suspect discussions were influenced significantly by that cultural and moral milieu. Although this early experience may have been little more than naïve child's play, the memory of my grandmother's loving affirmation for my dream left an indelible memory and impetus for my subsequent career choice.
- The strong emphasis on service that was a repetitive theme in our local Mennonite Church certainly supported my interest in the medical profession.
- Returning missionaries often visited our local church. Many missionary couples included at least one spouse that was a physician or nurse. The idea of service, of helping people with limited access to other resources, and doing so in exotic, distant places captured my imagination.
- Even as a child I recall the respect and admiration that was expressed by my family and acquaintances for physicians and nurses.
- My aunt (my mother's sister) spent a great deal of time in our home when I was growing up. She shared many personal experiences as a nurse. The stories and the interactions with people intrigued me.
- As a student at Goshen College the more intense immersion in the Anabaptist Tradition and a strong sense of "call" (vocare) further confirmed my interest in and commitment to the medical profession.

Ethics and theological / faith development.

- Growing up in a rural Mennonite Church where only a small minority of members would have had more than a high school education, I don't recall ever discussing "ethics" or the term per se. Even in college I recall few discussions – and no courses – dedicated specifically to the discipline of ethics. On the other hand, the intellectual boundaries between theology, morals, and behavior were virtually indistinguishable. Living one's faith every day of the week and every hour of the day were important

43 teachings in the tradition. Therefore the development and evolution of my ethical
44 thinking was implicit.

- 45 • The following significantly influenced the development of my ethical principles.
- 46 • Teaching regarding *agape love* and non-resistance has been important in
- 47 determining norms for behavior.
- 48 • Teaching regarding *servanthood*. The experience of *foot washing* within the
- 49 Anabaptist tradition has been instrumental in determining norms for
- 50 interpersonal behavior.
- 51 • Teaching regarding “simple living” has been significant in setting priorities
- 52 for the way in which Lois and I choose to live.
- 53 • Teaching regarding Jesus as Christ and Lord of life.
- 54 • Teaching regarding non-conformity – *in the world but not of the world* - has
- 55 been influential in my sometimes non-traditional choices within the
- 56 profession.

57 **Characteristics of Anabaptist / Mennonite Theology**

- 58 • Jesus is the Christ. Jesus is the touchstone, the norm for behavior. Thus the Sermon
- 59 on the Mount becomes a guideline for daily living, not an ideal for some future
- 60 kingdom.
- 61 • Agape love is a *modus operandi* for interpersonal behavior
- 62 • Honesty and integrity in relationships
- 63 • Sanctity of life
- 64 • Non-resistance, pacifism
- 65 • Non-conformity
- 66 • High priority on community (church) and mutual caring
- 67 • Servant leadership
- 68 • Separation of church and civic authority
- 69 • Evangelism through service
- 70 • Evangelism through service
- 71 • Evangelism through service

72 **Conflicts between profession and theology / ethical teaching**

73 The following illustrate several circumstances where I feel conflict between
74 professional obligations and beliefs / ethics.

- 75 • Servanthood vis a vis the paternalism that was part of the professional acculturation
- 76 during training.
- 77 • Recommending abortion – I do so because it sometimes is the best alternative among
- 78 several unsatisfactory solutions to difficult social problems.
- 79 • Managing patients with behavioral disorders, mental illness, etc. Given the power of
- 80 new drugs, do we control behavior to conform to normative behavior? Some of the
- 81 world’s great artists had bipolar disorder. Should individuals be controlled to such
- 82 an extent as to compromise creativity?
- 83
- 84

- Contending with the imposition of market theory in physician-patient decision-making. The US has resorted to imposing financial risks on decision-makers (physicians and patients) as a means for reducing cost of health care. This pits self-interest against the interest of the patient and creates conflict with traditional medical ethics and my personal ethics. In my current position, this is the most difficulty conundrum that I face. I believe it will be a major ethical dilemma for the profession for the early part of the 21st century.
 [While you're living in Britain, you may want to read George Bernard Shaw's play, the "Doctor's Dilemma." Be sure to read the Introduction. Shaw was 100 years ahead of his time describing 21st Century medicine in the US.]
- Managing patients at the end of life. Participating in the irrational prolongation of biological existence through technological interventions runs counter to personal beliefs about the sanctity of life.
- Ethical dilemmas encountered in the conflict between individual good and social good. The individual may pursue a course that utilizes scarce resources in a way that is detrimental to the social good – "The tragedy of the commons." This is a significant problem for those of us involved in public health.

Developing a framework for Anabaptist / Mennonite Medical ethics

- Features of Anabaptist / Mennonite theology that influence a unique medical ethical perspective.
 - *Sermon on the Mount* as a guide to daily living.
 - Service motif
 - Non-resistance, pacifism
 - Non-conformity
 - Priority on community – the church constitutes the Kingdom of God on earth.
 - Separation of church from civic authority
- Does the Anabaptist Tradition offer a unique perspective on medical ethics?
 - Yes, though I'm not certain that I can articulate it well.
 - Servant leadership offers a unique perspective on the physician-patient relationship.
 - Importance of the community in the Anabaptist tradition has implications for the individual – population ethical conundrum. However, I'm still trying to resolve this issue for myself.
 - Appreciation for the sanctity of life has implications for the evolving genetics technologies.
 - And the list goes on . . .

Preparing a curriculum for medical ethics – I suggest inclusion of the following topic areas

- Explore the interface between spiritual belief and moral / ethical decision-making.
- Ethical decisions at the provider / consumer (physician / patient) interface.
 - Managing decisions at the end of life, e.g., prolongation of life without regard to quality of life, cost of care.
 - Abortion – include discussion of prenatal testing for congenital disorders and decisions regarding termination of pregnancy.
 - Managing difficult patients, e.g. terminating a professional relationship.
 - Inclusion of spirituality in the “holistic care” of patients.
- Ethical issues surrounding the explosion of knowledge regarding genetics and the implications of that knowledge for managing disease in individuals and populations.
- Social ethics and implications for managing public health and economics. When does the “social good” take precedent over the “individual good”?

1 Dr. J. Alexander Bartel

2 > Chilliwack B.C.

3 > GP, chief of staff,

4 > emphasis on serving, integration of faith and life, simple life style, individual in
5 community, non-violence, peace and community, **choices** for the individual, being
6 able to make decisions, enable to make decisions, support patient even though
7 choices might not be in accordance with MD;

8
9 **When you look back over your life and career, an especially at the beginning of**
10 **your career as a doctor, do any specific teachings of the church stand out**
11 **instrumental for your choice of career?**

12 I think my up-bringing, having grown up in the Mennonite Church there was
13 always a very strong commitment to the caring part, the compassion, the peace
14 position of the churches teaching. There was always a very strong influence in my
15 home to care, the caring part has always been very strong. There was an emphasis not
16 on making money important, there was an emphasis on sort of life styles that were in
17 keeping with the theology, I guess you could say. And so any of those caring, healing
18 sort of things have been looked at positively. Even though I think my parents
19 probably gave us lots of choices also. Put it this way, there never was an agenda as to
20 what I should become, there was never any push towards that. But I think in most
21 churches, medicine and those sort of caring professions, and teaching and some of
22 the professions that dealt a lot with people were I think more acceptable. So saying I
23 want to get into business and become rich, if you made that kind of a statement that
24 wouldn't have got any points or the same amount of support.

25 I grew up on a farm, on a dairy farm, and sometimes I kid around and said, 'if
26 there would have been a veterinary college close by, I would have gone into that line
27 of work, closer to family work, and I always had horse. There was no vet college.
28 Sometimes I wonder whether medicine was really a choice, I don't know. I probably
29 decided on medicine in highschool. I've thought that would be an interesting thing, I
30 enjoyed the biological sciences, did ok in school and so on.

31
32 **So service was probably the biggest thing?**

33 Service was an important one. I guess I [was] sort of thinking what my
34 brothers are doing, I have 5 brothers, so teaching, and medicine, I'm the only one in
35 medicine. But there was never really an agenda though either, I was sure not
36 pressured in any way by my parents to pursue a particular type of occupation. It was
37 more saying, 'choose what you want but follow Christ's teaching in the line of work
38 that you choose,' I think was more the kind of message I got from my parents.

39
40 **So Christ's teaching you would identify as serving humanity? Any other**
41 **teachings that stand out?**

42 Well, I think, I've had discussions with people, you know, 'is it God's will
43 I'm a doctor', I don't think it's God's will I'm a doctor, I don't think it's God's will at
44 all. It's God's will of what kind of doctor I should be, and so I'm a big one on choice.
45 I like choices and I think God gives us choices, and that sort of stuff. But the kind of
46 choices is how we relate to people, I think it has to do with caring, has to do with
47 compassion, it has to do with going the extra mile. Some of us have to watch that,

because we might become exhausted as we go the third and the fourth mile and at what point are you're saying 'I'm not going any more miles in health care.' But I think it has to do with that whole thing, something has to do with healing and touching and carrying burdens, and I think all those things are really important to me. So when I look at my theology, I've often said that's the important stuff, what does it mean to be a Jesus follower today? So it has to do with all those hand's on type components, rather than having a belief system and some... **theoretical treaties?** Yea.

When you think of your own spiritual development, and I know, I fast come away Mennonites have all grown up like this and therefore they all are like that, its not true, everybody has their own unique story of struggle and making their faith their own. But your own spiritual and theological development, is there a place where you would put ethics? Is ethics something that comes from theology or spirit, or does it not, is it not anything separate? How is that going in Mennonite theology?

Ethics by the word is something that I hear more recently, so we're actually putting words to this process in the last number of year as we starting to grapple more with some of these issues in church, whether its life issues. I guess one of the first issues that sort of came up years ago is the abortion discussion where we started what is ethics? I think way back we wouldn't have had a label to it but was still happening in a sense of expectations as to how we should relate. My own story probably, I'm related to it to some degree.

I'm more a German Mennonite, I'm from the Mennonites that never left northern Europe to go to Russia years ago. My parents are ethnic German, they grew up in the Danzig area, and then after WW II fled to West Germany and then immigrated to Canada as refugees in the early 1950s. So my father was an officer in the German army, the Mennonite church at that time had lost its peace position, it's General Conference Mennonite. Then I think my father's own pilgrimage back to a peace position and his own struggle with that, probably had an influence on us to sort of think through our faith. So it was not an easy faith, it was not easy. There was this component of working through what does it really mean, instead of sometimes we tend to drift along in our comfortable affluence, and we go to nice worship services. Its not [that] that's not relevant but we are not forced to say 'where is the tuff stuff'. I think maybe my own family and coming to Canada as refugees with absolutely nothing, having been sponsored through MCC, and my Dad's own personal struggle to come to terms with what happened to him as an officer in the German army. He has actually written a book, and published it, he became a peace activist for MCC. The book is called *Living with Conviction*, was published by CMBC, by Siegfried Bartel. Its available in Christian book stores. So I think my Dad is also a very important person in my life, he's a thinker but also as a man who has pushed us to sort of think through what it really means to apply our faith in daily living, and as a lay preacher and so on. So I'm sure I was exposed to a lot of ethics before I even knew what the word meant. I was by our whole family situation and working through the early years of farming and so on.

Are there teachings of the church, like ethical teaching that you can think of, that you would clearly classify as ethics? Or is it more like the stuff you do?

Well, I think three weeks ago I attended a bioethics conference hosted by the Catholics Physicians Guild. And they had a priest and an ethics professor out of Boston there as a speaker, a polish last name, Father Graham something or other. Anyway, its interesting that when we [Anabaptists] get together and grapple on ethics issues we'll say, well what about this verse in the bible, what about Jesus says here, what about this reference in the Old Testament. In that context, he says, the Church says this, the bishops council of the US says this, and the Church says that, and the writings where very well thought out. But the reference was the Church, and the reference what the Pope Pius or Pope John or whoever wrote [it]. And the writings were significant. Why am I saying that? We as Mennonites haven't done that. I would very rarely say, 'the church says this'. We probably because of our thing about the priesthood of all believers have often therefore also diversified a lot in what our interpretations are. So if you saying what does the church teach? As far as churches teaching, we come up with general concepts, but we don't have really clear teachings. And that's why we have those tremendous dilemmas now on homosexuality or abortion; euthanasia we don't have as much dilemmas, because nobody is really be keen for at least active euthanasia. Its not as big an issue, well, it hasn't touched us as closely. So the churches teachings, again, the ones I hear are more the general ones, caring, compassion, the value of persons. So, rather than saying we have one teaching on what it means when life begins, so we haven't picked up the ball. On the other hand, we have more room for some of the choices, but with that comes more so often a diversity. So if we then try to pull together and say what's our real stand, we could only have a fairly broad statement because we have this diversity if it gets much more specific. We could probably write some things on abortion, but it might not be as specific as some people would like [it to be].

The Diversity that we have, which is great and which we all embrace, is also down-side because it lacks coherence. ?

Absolutely. And some of us are comfortable with the diversity and some of us aren't. And that's why some want to leave the Mennonite church because it is not specific enough or they're saying 'the church has not taken a strong enough stand on the gay issue, so I'm going over there to the conservative evangelicals'. You got to remember also where I come from, I come from British Columbia. And the Mennonite church there has been strongly influenced by the fundamentalist and evangelical movement. And to actually say the word Anabaptist in some Mennonite churches [there] raises a suspicion that you also may call God woman, and maybe you are from the East somewhere, where [they] loose theology and, I'm over stating it somewhat, ok. But I struggle [with this], I think we as Mennonites loose our identity as we become, some churches especially become engulfed in the somewhat conservative evangelical movement. And in that movement we also can only make..., in that movement our theology becomes relatively narrow, and very black and white and for some that's quite comfortable because 'hey, we don't have to sit and have a long dialogue about the gay issue, that's clear cut, says so in the bible, end of discussion'. We as Anabaptists, as we grapple with what does it mean to be a caring, supportive community in light of this, 'hey what do you talk about this, we dealt with that a long time ago, we're on to praising the Lord'. I'm overstating it, but you know what I'm saying.

142 So you know where it's from (the conservatism). And so and I think that is
143 why its really important... You know, I mean, Why am I at this conference? Its
144 because I think we as Mennonites and MMA have something to add to the
145 discussions on ethics, on issues that we are facing in life. I'm also a member of the
146 CMDS, there's a lot of good people there and a lot of good stuff there, I sure don't
147 want to say anything negative. But it a very evangelical, somewhat conservative, sort
148 of straight line thinking, and I think we need to balance that out and so I'm just
149 saying, MMA, which is been generally an Eastern American phenomenon has
150 relevance in Canada, has relevance to us out in the West out there. And even though
151 there's only 6 or seven Canadian members in the whole association. This is the first
152 time ever that they have met in Canada. **And I've talked to two already?** That right,
153 and the ones that are here, are gung hoe. But if you look at the membership, there is
154 very few Canadians. And its because we just haven't been in touch
155

156 **Let me go back on the to your work as a physician. So you say theology and**
157 **ethics didn't necessarily live through a separation earlier on, ethics is what you**
158 **did because of what you believed with the caring and the community and all**
159 **that kind of stuff.**

160 Yes, absolutely.

161 **Have you had experiences in your practise were you knew this is what I believe,**
162 **but this is what I'm faced with and I'm looking at a dilemma here. How did you**
163 **resolve those issues? So I guess the question is, are there any issue that you**
164 **faced because you're Mennonite and MD and how did you resolve those issues?**

165 Sure there are. I think you summary is right, I think when I grew up because I
166 was brought up in a place where there was a lot of dialogue in the family, we didn't
167 need an ethics committee, because ethics was part of the whole working out of our
168 faith. When I came out though, there are a lot of things. I mean, if I think way back,
169 I've been in practice 23 years, general practice, emergency, maternity and so forth. I
170 was also pretty sheltered back then, I grew up on a dairy farm. I didn't know much
171 about divorce and abortion and all that kind of stuff, somehow I assumed divorce is
172 probably wrong and some of those sorts of things, and marriage is for life. And I
173 think one of the first issues, is sort of saying, wait a minute, there is some
174 relationships here that, I don't think no matter what it says in the bible, that woman
175 should not stay in that relationship. I didn't know much about spousal abuse when I
176 grew up, guess I heard about it, but it was never in contact with that.

177 So one of the early issues was saying, wait a minute, I have a certain view of
178 the family, of a husband and wife, and marriage and so on, and I have to sort of
179 stretch a bit on that, and sort of saying, wait a minute that's not that clear cut. I
180 remember years ago, when we first got into the abortion issue. I remember raising it
181 as a young person, as a youth person at a Mennonite conference and I was actually
182 quite shot down for asking a question about it, because this doesn't need any
183 discussion, all abortion is wrong. And then, being faced with teenagers where the
184 birth of that child would be absolutely devastating and you're trying to be caring and
185 supportive person in a place where you saying, but terminating the pregnancy is not
186 right either. I have seen some pregnancy out of rape situation, I've had the dilemma
187 of a 42 year old lady who had a Down syndrome child and wanting to terminate. And
188 [I had] also a person with a Down syndrome child who would never consider

189 termination. So I think that whole issue of how am I a physician as a caring
190 supportive person to a patient who is planning to make a decision that I'm really not
191 comfortable with. So that was probably underlying that whole issue. My patients
192 know where I stand, I've often told them that I would support them as person even
193 though I would not necessarily support their choice. But I would not terminate my
194 relationship with them and so on and so forth, as physician even though on the
195 abortion thing, most of these people would need a referral to somebody, and I would
196 not do the referral.

197 **You would first of all not do an abortion?**

198 I would not do an abortion.

199 **And second of all not do referrals either?**

200 I should say I have done referrals. And there's still one that stands in my mind. I was
201 early in practice, I wanted be liked, we all want to be carrying and we wanna be
202 accepted and I didn't stand up very strong. And there was a school teacher, she's still
203 a patient of mine, and her pregnancy would not fit in with her plans, that sort of
204 thing, and I referred her to an OB-GYN, in Vancouver, they did an ultrasound, this is
205 20 years ago, they did an ultra sound and the child was beyond 20 weeks, and this
206 OB-GYN said in Canada its illegal to have an abortion after 20 weeks but I know of
207 somebody in Seattle that will do an abortion for you, [they] will do a saline
208 induction, and terminate this pregnancy. And she went down to Seattle, and had a
209 saline induction, which killed the baby and delivered the baby in Seattle and then
210 came back. She's still a patient of mine, and every time I see her, I feel some guilt. I
211 kind of wish she wouldn't come to me anymore, but as I said, I regret ever having
212 referred her. Because somehow, because I've also had cases, and I know of two,
213 they're also still patients of mine, where they came and wanted an abortion. I gave
214 them my views and I said: 'you know this is not really the route to go and I want you
215 to think the broader picture.' One I refused to refer and one I did refer but luckily the
216 appointment was 2 weeks down the road and during that time she gave it some
217 thought. Both of those are in my practice, one is a delightful 18 year old girl. And the
218 other one is probably about 12, so I know these children, and I know for a fact that
219 both of their mothers were in my office wanting abortions. And both of those
220 mothers have kept those children, and both of those mothers are happily married, but
221 both were married when they asked for the abortion. They wanted to terminated
222 because it didn't fit in with their plans, or didn't want children. One lady has had a
223 subsequent child, the other just one, they just had this one daughter. So I look at them
224 when I see them, and I don't say anything, I would never say anything to the mother,
225 but I know, I know that those mothers had come in asking for an abortion and I had
226 refused.

227 So, when I look at that and I still feel the pain of that one lady who I still feel
228 somehow responsible for that late abortion. I now tell my patients, my patients know,
229 lot of my patients know me well and they say: 'Doc, I know where you stand on this',
230 and I had this gal lately recently and she says: "and that's ok doc, I can access that
231 system, I can go to the planned parenthood clinic, I can get a referral for that.' And I
232 say: 'I appreciate if you do that'.

233 **So Relationship seem to be much more important, or equally important**
234 **as medical treatment?** Yes, and sometimes we all have this, you know, I have this
235 crazy need to be needed, I have this crazy need to be liked, I don't wanna take a

stand, I want everyone to be happy, and so maybe somebody says 'come on Bartel that's a compromise', that's where I'm at with it. To me it's important but also to say 'I'll walk with you but I can't walk down that road, don't ask me to walk down that road'

If you think of your practice now, are there any ethical dilemmas that come up more than others? Its probably broad spectrum when you in general practise, but anything that's coming up more than others?

Well, when the topic of ethics comes up, people often will say ok, well they think about abortion, and now some of this conception stuff and so on, they think of end of life issues. Those are the popular ones, and so on. I guess ethics though is everything we do, ethics ties in with all those decisions, ethics has to do with how I relate to my patients when they phone me at home, my home number is in the book and I'm tired and how I relate [then]. And ethics has to do with what I say. Last week I had a patient of 64, she had breast cancer, metastasised her brain, I made a number of house calls, she passed away in her home. Ethics has to do with how I related to her, and how I relate to her husband, and that sort of things. So, issues as far as that goes, maybe, well.

The end of life ones probably. One of my other jobs is I'm chief of staff of our hospital. So I'm appointed by the board, I'm hired by the board to oversee health care and be involved in a lot of the funding discussions. And so where ethics might come in also [is] in the discussion and decision making as an administrator which is a little different from my actual patient practice. Ethical discussions, ethical decisions, I think some of the tough stuff is - and maybe it's not ethics as much - I think the whole dilemma with terminal care probably. Walking through that, when do you say enough is enough, and working through some of that quality vs. quantity discussions, of saying well, maybe that treatment might give you few more weeks but are they useful weeks for you and your husband, when I think of that breast cancer patient. Trying to apply those sorts of tough things, I don't know. What are some other issues?

You know, one can talk about terminal care as one of the ones. Is an IV treatment or care? Is water, is food and water treatment or is it care? Should you discontinue when someone has had a stroke and is not recovering from that stroke, and they've had an IV put up, is it ok to turn that IV off and let them slip off into dehydration and come to the end? Or are we obligated to provide IV therapy till they die? Am I obligated to treat a pneumonia in a terminal patient or should I say, let it be? I guess I compare myself to some of my very evangelical friends who are very strong pro-life. I'm a little more liberal in turning off IVs. I'm a little more liberal in saying to the family 'look, let's not do more blood work, I don't really care, not that I don't care, but what the potassium level is or what the chest X-ray shows really doesn't matter anymore.' So I'm more prepared not to treat a terminal pneumonia. Whereas I know some of my evangelical friends would say, 'look, you got a pneumonia, you know you got something in your pocket that would treat the particular complication, you should treat that.'

So what you're saying is that you try to see more the whole picture of where the patient is in?

Absolutely.

With socio-economic, spiritual, emotional, terminal, diagnosis, where as your evangelical doctor friend would see more the clinical picture?

Yes.

And they say this what I'm called to do, that's why I am a doctor

I've got to support life not matter what. I see a pneumonia, I know I can treat that pneumonia, I see that this person has a high potassium or low potassium, or I know the blood levels, I know they are quite anaemic, I know I could give them another unit of blood and could bring that blood level up and maybe that will support them a little longer. I'm much more into sort of saying at what point are we really prolonging something. And if the patient really want, I'll run an IV, but I'll tell you, I'll let them know that I really don't know if that does it.

So when you think of, you just said that Anabaptist theology includes like the caring, compassion, community, that kind of think. Now, you're asked by MMA here to chair the subgroup of medical ethics, and you have to come up with a proposal what of Mennonite theology do we put in here, and who do we argue the point that this theology has to be here because it supports medical ethics. What would you put in?

Well, there are two things: respect for all people, with the bias for life. A respect for choice, choice is a bad word because of all the pro-choice movement, but a respect for choice. And I think that I need to leave room for choice. Now at what point would you say 'well, you can just choose anything', are there no limits to choice? Of course there are limits to choice, so you gonna say, ok what are the limits? I like to give my kids lots of choice but I still set some limits on their choices. But there is something, I don't know how to word it, something that says you respect their individual worth and their desire and their opportunities to find that, I mean those are very general terms. But sensitivity to that, and judging actions, someone else's actions are something I want to be very cautious on. Unless someone very directly adversely affects someone else, saying 'you're not allowed to do this or you're allowed to do that', I have a bit of a problem with that. But now you're saying when do you leave individual's choice, a physician's choice to act a certain way? When do you say as chief of staff then well, 'no doctor you can't do actively something,' that sort of stuff. Maybe if I could word it, is compassion especially for the disenfranchised, I mean we need to really advocate for them and give people choices, something like that.

Disenfranchised, as in, how would you put that?

I guess, in the health care system I want to advocate especially for those people who don't have an advocate. So maybe it would be more making sure that the right of the underdog are also included. I may be a little less worried about, well, you're not helped your system, even though in Canada we have a fairly universal thing, there's certain people who might not have an advocate in the system and can be easily passed by. Even in our universal health care, and so if I think of who I really want to speak for those that may not have a voice. I don't know, I'm rambling on.

Not you're not, I'm just helping you back on track here. Off the top of your head, do you find a Mennonite theological teaching that would support the underdog, that's helping the underdog?

Oh, I just look at Jesus' example, what are the kind of people he related to, and so on. He didn't advocate for the rich, but he sure advocated for those in need and the sick and the beggars and the people who didn't fit into their society and so on. And you know, when it talks about 'blessed are the poor and the meek and the weak ones', I mean, I think the whole message of hope is one that relates to the poor. And those are not always the poor financially, I think those can also be the poor in the sense poor in the way of contact, poor in the way they might have lots of money, but they have no friends, no advocates, nobody walking with them. And so if there is one thing that's important is this whole thing about walking with people. And I think that's what Jesus did. So it's not so much... yea I think that's where it is.

Am I totally off on a tangent here with my thesis, or is there a particular Mennonite approach to medical ethics?

I think at this stage we don't, I think we're so diversified, that we have [not one approach], I don't think we have one. **If we don't have one, should there be one?** Absolutely, absolutely, should there be one. What is it? I think that's why this group has relevance, that's why I'm here, because I think we as Mennonite physicians, nurses, and health providers need to speak out on some of the issues that are facing us. And I think we do have [a] unique voice. What is that? I think that has something to do with again caring and compassion, it has to do with not allowing us to be totally sucked up into the materialistic world, not being sucked up into what's being best for me, and to say no, we're here because we wanna care what people.... I don't know, it has something to do with...

On this whole homosexual issue, I don't think that this group can come up with one statement on homosexuality. However, I am distraught over the kind of animosity that has cropped up within churches and between groups as they dialogue, I was gonna say dialogue, it's not even dialogue, as they shout at each other over this issue. And maybe we can't be given a final statement on homosexuality as a church, but I think we as physicians and as healers along with other groups, can talk about healing within the community and what does it mean to be a community, a family of God with all our various imperfections. And maybe we can be a voice of sensibility in this turmoil, and maybe being Jesus' followers is sort of saying Jesus stepped into a lot of real tough issues in his time. And I think we as a Mennonite church maybe have been reluctant, maybe we jumped into camps but are not prepared or haven't gone in between the camps. So as individuals we bought into this or that, and I think, maybe I'm overdoing the peace position, but I think some of our unique stuff about compassion, and not that other people have compassion and peace, but our peace position, and those sort of things should be an important part of helping the church dialogue at least on some of these issues.

At this stage we have not sat down and said this is our position, if it is, then it is not going to be a black and white statement, another black and white statement on euthanasia or abortion or homosexuality. If we need to write something, then it has to emphasise more what it means to be a caring and compassionate family that is seeking as best we can in our imperfections to follow Jesus. And so I think our, if

there is anything unique about us as Mennonites it is the importance of being Jesus followers, and into this world. And so that were I think our uniqueness is, so our uniqueness is somewhere in between.

So it's basically following the sermon of the mount, peace, non-violence, the stewarding of resources, and the community support for those who are not able to support themselves?

Yea we've talked a bunch here at the conference on access to health care. And we've talked a bit this morning on the difference in Canada, which is universal health care, but everybody in the population suffers some of the gaps of health care in Canada. In the USA, I never practised there, but over generalising, there is more of the rich and the poor. If you have a good health care plan you can get all the procedures and the opinions, and if you don't, then you don't and if you're really sick then you go to the ER and get looked after. There the gaps in health care are felt by only a part of the population. Most of us Mennonites are well off, hard working and most of us are probably in that group that has access. And so we need to address both in Canada and the US equally, where is our responsibility in that gap? What kind of decisions do we make as individuals, and as individuals [what do we] say to our government about those gaps. And so that ties into Christ's teachings and relationship to the poor and the rich, and the responsibility of the rich. Most of us are in the rich group, and so if I think of ethical decisions, it has to do with my responsibility towards the poor, or the working poor, or those who don't have access to health care, that sort of thing. And then, I'm sort of saying well then, ethics again becomes, here I'm going back, ethics is something I guess it's something we live, I'm not a learned person in these sort of discussions. If you ask the average person about ethics, I think then that's about issues. I guess the more I think about it, the more I think ethics has to do with how I live, ethics should be part of my everyday decision making. And I think the church needs to heard in that, and if there one message again I think it is back to applying Jesus' teaching and examples as we make those decisions.

Ok one last question: the president of Canadian Bible College is calling you, saying we heard of your reputation as an excellent physician and we need somebody to put together a Medical ethics curriculum for CBC because we want to prepare our students very well to go into med school and we want them to be able to have thought through stuff, from their theological perspective.

What do you put into that medical curriculum? What is burning on our heart?

Number One: I think it has to do with personal life, in other words, start with ones own values, and what are those values. You would have to stress something about the, we've mentioned care and compassion, we've talked about cautioning, we would have to talk about how do we make financial decisions, in our own life. In other words, stewardship, not only money or also of time, so its very much a stewardship thing. Do we make decisions based on finances, vs. what's best for my patients, or best for the community, that sort of stuff. What's my value system, and we are so inundated with worldly value systems, of what is important and what is not important. A lot has to do with finances, lot has to do with pleasure, lot of it has to do with the things we're caught up with. And that can take away from what's really

important in life, what really counts. And so it has to do with one's personal values, as to what's important in life and then bring that out into how we help people process issues and so on.

So from there, things about the value of all life, and then what does that mean, so you have a discussion from that. From this recent conference I was that, the Catholic one said, he has a 'bias for bios', and I thought, there's a good line, that's good, a bias for life. In other words, that's an underlying bias and then we have to sort of flesh this out, when is it ok to say now it's ok to let this person go, but sort of [with] a bias for life.

I would somehow emphasise that life in a broader term, and we need to define that more. I'm frustrated in times when my pro-life evangelical friends support capital punishment then I say, wait a minutes, something is hay wire here, I need a broader definition of that.

What does it mean to be caring? Process that. And then the other thing we talked about earlier is this whole thing about choice. And when is giving someone choice is giving them personhood, for lack of better word. I've often said, I've picked it up somewhere, what is God's first commandment to Adam: do you know what the very first commandment was to Adam? I can check this, I think this is true. The way I understand it, [the first commandment] is to name the animals and to me this is very significant. God says, 'you want to call that funny looking horse thing a zebra, that's cool. You wanna call that a lizard, we'll call that a lizard.' In other words, God approached us with, gave us a responsibility. Said, 'hey, you got a brain, you can think this through' and I'll go with it. So I think choice is an important thing God gives us. It's also a risky thing to give [us choices] because then we might make the wrong choices. So I want to give patients choices, I might wanna give them the information to make the kind of choices that I think, I want to have the freedom to give them my opinion without making them choose the way I want the to choose. Because I think that is all part of freeing, part of letting go, but also recognising people's worth.

So if an ethics thing has to start with ones own life and what's important in your life and then if its important to you that sure its important to someone else, something like that. I think its not just abortion and euthanasia, its much more about how we treat people, how we respect them, that sort of stuff, somewhere in there.

I think first of all Mennonites are very diverse because of this group that geographically were at very different areas and prior to global communication and everything else all these different groups had somewhat different ideas. So although we have a Mennonite trunk here there is a fair amount of diversity. And then also all these other influences, especially on all those things in the church really, I guess makes you ask 'what does it mean to be Mennonite'? And that's a key question. And we see that out West where churches say maybe we ought to remove Mennonite from our church name, we are now XYZ-Community church. And we say, wait a minute, there is something unique and that's what you're trying to say, so you say tell me what make us unique. I think it's got to come out, and I haven't read a lot on it, but it has something to do with really following Jesus. I think there is a real desire there, not to belittle the Old Testament, but it has to do with not just high-in-the-sky-by-and- by, it has something to do with the tuff stuff today, and it has to do with walking with people even though we're in awkward situations and we have to somehow asked

471 to not be arrogant. Some people say, I know how God relates to homosexuals, I think
472 that's a statement of arrogance.

473

474 Well, thank you very much for another interesting interview.

1 Dr. Cecilia Brennan

2 > Internal Medicine own practice sold to Community Hospital;

3 > in medicine for 35 years,

4 > organisational problems with practice at the moment;

5 > important focus on public policies, service, equality of all individuals, 'doing what
6 Jesus did', being called to services, social justice, community, developing world,

7
8 **1. At the beginning of the career, are there any specific teaching that stick out in**
9 **your mind that the church taught you that was instrumental for your choice of**
10 **career?**

11 For my choice, yes. I remember when I was deciding what to do with my life,
12 when I was realising that I like science and health and so forth, I remember having
13 just a real fear that the worst thing that could possibly happen in my life would be
14 that I would live my life and get to the end and realise I haven't help anybody. I just
15 felt more fear and concern that I could live a life that didn't help other people than
16 that I would live a life of poverty or a life of illness or whatever, nothing. No fears of
17 being lonely or anything, nothing seemed more fearful to face at the end of life than
18 that I had lived selfishly. And I really think that that attitude and that paranoia of 'oh
19 that would be the most dreadful thing in the world' comes from the teaching that we
20 as Christian need to be the hand of Jesus. We need to be making a positive difference
21 carrying on his work in one way or another. Whatever way suits us, teaching, making
22 music, whatever, but something that was just a strong motivation.

23 **Is there any other teaching, besides being the hands of Jesus, is there any other**
24 **teachings that stick in your memory that would be important**

25 A song that has helped me to focus at many times in my training. The song Jesus
26 loves the little children, all the children in the world, red brown yellow black and
27 white, they are precious in his sight. And I've had to take that song apart like word by
28 word and ask myself do I believe that. Are all the children precious in his sight? Are
29 the precious in his sight? Are they precious in Jesus sight? Do I really believe that?
30 And yes, I do, therefore if that is true, then I need to love the little children and the
31 big children, the children that grow up. So since God loves people and they're
32 precious to him, that's just like foundational, they are precious, people are precious,
33 that just part of what we believe and who we are that people individually, colour
34 doesn't matter. But people individually are precious to God. Stuff isn't precious to
35 God, things aren't, but people are.

36 **So its more the focus on people rather than things that were important to you in**
37 **the teaching of the church?**

38 And then another one, this isn't a bible verse, but phrases ringing in my head
39 over and over. When I was a child we got a movie at our church and we were played
40 it over and over again from world vision. And Bob Pierce, it was about the work that
41 they were doing with leprosy, and Bob pierce one of his famous phrases "let you
42 heart be broken by the things that break God's heart". And I think I might have been
43 10 years old but that just really impacted me, to see suffering people and than have
44 my church teaching me through the voice of Bob Pierce and world vision, that it was
45 right, that it was the thing to do to let my heart be broken. And that stuck with me,
46 that was the way we should be, that how we should act. We shouldn't resist, we
47 shouldn't turn away, we should be involved, we should allow our hearts to be broken,

we should allow ourselves to be motivated. Those were teachings that came through the church that helped to mould me. Then the phrase 'what would Jesus do'. Now its gotten rather, kids can by braceletts with WWJD, but I can remember a number of time into my training when I met really difficult patients, and they are there, people who were ugly or mean or cheating or abusive, or whatever, and before I would interact with them I would pause and think 'what would Jesus do?' How would he deal with this person, how to convey to this person, that they are loved and they are worthy. But he wouldn't take any nonsense either, he would have be straight with them. Ok, so be straight with them, treat them with respect, love them, you know that kind of echoing in my head just the phrase 'what would my role have done'. So I shouldn't do this, I should to that.

2. When you look back over your own spiritual and theological development, can you tell me where you find ethics located in your own development? Where do you think it started? Where do you think you own ethical reasoning came and how do you think that connects to the theology you were taught?

I have to say my own pilgrimage was very disconnected because I was taught things and then I didn't see them modelled. For example, I was taught the value of the human, but the very person who taught that, my father was my pastor, was he was racist, and he was anti women, he was very disrespectful of minorities, he did not treat people with dignity. So I heard that from the pulpit but, when I was a child I had to deal with these kinds of things. Thank goodness my mother was there, she wasn't the preacher, but she was a very good example. But it was confusing to be in an environment where patriotism and white, my Dad would have never considered himself a Nazi or a Fascist, he would not want to be called a racist, or a sexist. So to be fed, as I was cutting my teeth, feed this kind of attitude, and seeing when it was expressed all around us by other people, it was been opposed. So I had a very confusing environment to grow up in, so what we were taught and what we saw modelled was often very different. And I had to deal with that from when I could first think for myself. And I remember as a child in school, arguing with my father about the way he talked about blacks, I remember being taught that Martin Luther King was a communist, and until I was about 30 years old when I realised who Martin Luther King was, I realised, wait a minute, he wasn't anti American communist, he was a wonderful leader of our country. He wasn't somebody who was out to destroy people, he had all of the negatives that was attached to Godless atheistic communists, as I was growing up, those were the people who did the civil rights. But it was not until like I all of a sudden realised "wait a minute, what was I taught, what in the world was I fed?" Some of these things I had digested and rejects early, but some of the thing I had just never dealt with and understood the implications of what I was taught.

So ethical teaching in the church where do you think it happened?

Our church didn't deal with kind of the real life issues. But our foundation, (it wasn't a Mennonite church, by the way, I had never heard of Mennonites until I met my husband and then that was the worst unforgiveable sin I've committed against my father to marry a Mennonite, but that's beside the point, that's another story), but we were taught foundationally correct, I believe. The value of the human being, that God

loves us, that he reaches out his arms all day long to forgive us, that we are to treat each other well, and so the people who believed that in their deepest heart, but also hated black, thought that the civil rights movement was communist, believed that the US was supreme and God's special pets. They had to make room, the has to make room, the had to really do some mental gymnastics to make all of that fit. And when they preached it from the pulpit and they made it all fit, it didn't quite fit and I sort of knew that and kind of said wait a minute we got some problems here. But there was always too many thing I was dealing with head on in my confusing childhood. But I didn't take some of them apart and like I didn't realise until I was 30 that Martin Luther King wasn't who I was taught he was. And the civil rights movement wasn't the enemy of civilisation, these things weren't as my father and that group believed they were. **You didn't by chance grow up in the South anywhere?** No, isn't that strange, I grew up in the North. There were Bigots lived in the north too. Actually some of the influences I do think kind of drifted up from the South, for instance my father was in the military and spend time in the south. And so I think some of it just wafted our way and we didn't realise the source of it. But the deeper things, the truths that we had to deal with, that were truths and are truths, the people who were in that frame of mind had to kind of mould their attitudes to make them sound like the really did fit with. It was very odd, very strange.

Now you say your husband is Mennonite? When did you start getting into Mennonite thinking, and when you think of that, what was many the most, or still is, the most characteristic that you would find being Mennonite or Anabaptist teaching?

I think Anabaptists do the theology on the road. I think they have a theology that is transportable, that fits into different settings. Like the people I grew up with, their theology only fits in suburban, white middle class America, it can't go to Zimbabwe, it doesn't fit there, its not the gospel that you gonna hear in Scotland. Its the gospel of white middle class northern USA. But the Mennonites really have a theology that isn't just for the Mennonites in Eastern Pennsylvania. Its a theology of how God looks at the human but it fits in the African human, and the Asian human, and the European, and the South American, and Central American. Its much more real, and its much more able to be taken right from the scripture to where I am here. Like what does what the revealed nature of God, how he wants us to relate to each other, how does that apply to us right here. And then how does it reply to our brothers in Honduras, and our brothers and sisters in Iceland? Were taking God seriously, we're a kingdom of priests, we're all meant to access the throne, and we're meant take those truths and live them out where we are. The gospel changes and converts society, society doesn't change the gospel.

So if you would have to make a list of Anabaptist teachings, lets say one of your patients come and they have not a clue what it is, but they know you're going to a Mennonite church and then they ask you, so what are the Mennonites all about? What would the nutshell characteristics be that you would give them?

First of all I would say the Mennonites are Christians, they believe that we are to follow Christ in daily life, to the best of our ability where we are So we are Christians just like the Presbyterians are Christians and Catholics are Christians. We

believe our faith is based on our example Jesus, and our foundation is a faith that he is the son of God and he is God's revelation to us. SO that we have in common with all of Christendom. But then the most what I would believe the characteristics of the AB, that I believe all Christians would claim, but Anabaptist manage to live it out a little better, is that the, when Jesus said, he meant for us to figure out what he meant and than do it. Now we figure out what he meant to say, what he meant to say and how that would apply to us today. And the bible is to be applied to where we are today, it was written to the people in the first century, but whatever aeons before that, to express the will of God in that setting. But the same principles are to be lived out in our setting. And then when we figure out what we're going to do, we go do it. We are not all going to figure out that same thing. Some Mennonites are going to believe that God wants us to dress funny, or do this, so we are not all going to come tot he same conclusions, but the mind set is that we are to really do that. When we figure out what he means for us to do, we are to do it. I think that is a characteristic of then Anabaptists.

If you think about it like Methodists have this, they're very active socially, Baptists are very evangelical, Nazarenes are more into Holiness, Pentecostals are into speaking in tongues, what do you think Mennonites are known for?

I think community, living the faith out in the real world, giving expression to it in the real world and basing our communal life on those principles. And finding the answers together, consensus, that kind of thing. Mennonites don't tend to be lone rangers, we don't tend to pick an evangelist and idolise him and give him liberty to do whatever he wants to do. He's got to follow the ways of doing things that we as a corporate body believe to be right, he can't change the rules. He can't come along and kind of preach a new theology. We don't endow in our leaders, at least in the usual situation, we don't endow in them the right to charismatically take people away and build a new understanding of God or new institutions. Community is very important. That's a real check and balance to keep people from getting kind of, oh what's the word I'm looking for, keeping people in the tradition.

When you were talking earlier about serving God and being Jesus hand and feet in your job, was an important influence for the choice of your work as physician, where do you think those principles of serving and of community and of what would Jesus do surface?

The principle surfacing for example I have never, never turned anyone away who couldn't pay, I have never said 'you can't come if you can't pay me', even when the practice was mine. I would take care of everybody, nobody ever was refused access to the practice because the couldn't pay. Even if they owed me 3000\$ and I knew they weren't going to pay, I knew I was gonna kiss that money good bye. Now I might have, if I knew they'd owed me 3000\$, not done lab work on my bill, but I knew I would have to pay for them. I might say "ok this is a dead beat, I'm going to give him his labs but he is going to he hospital. I'm not going to put another 200 on my tab, to follow his colestorol disorder. So I wouldn't do anything that would deny him access to care, he can go stiff the hospital but not on my bill. But it will be on my bill because I will continue to care for him. I will tell him he owes me money, at times send a bill collector to go get it, but if the bill collector write letters that would not express sentiments that I would express, I'd fire the bill collector. I will not let

somebody say things to the people that I care for that I would not say to them. So if I find out that they're harassing people and treating them differently in my name, that's it, I'm not going to relate to the bill collector. I want people to know where not in this for the money, it's not all about money.

So I would say anybody can come into my office. If they can't pay than it's not charge, if they can pay its partial payment. But I'm not a pushover, I'm all for calling people who owe us money, and I'm not at all happy to see people who owe me money spend money frivolously, I will talk to them about the fact that they owe money, so I'm not just afraid to tell people that they owe me or whatever. But I don't think Jesus would have either. I think Jesus would have gone for justice, and people all around him managing their affairs properly. And if you have money to spend, you spend it in the doctor's office for your health care vs. a cruise in the Caribbean. By blessing people to squander money when they owe me money I don't think that's Christian, I don't think that right, I don't think I'm helping them with it.

So you're saying that the one way that you see your faith living out in your everyday practise is helping disadvantaged people who don't have access to health care to actually get health care?

Right.

Have you every thought of the relationship between your faith/theology and ethics tha t you deal with in your everyday life? Where do you think that thing connects?

Yes I think it does connect, it does . The positions that I come to, some of it comes from my faith, my foundational belief that the human being is of value and that your financial situation does not declare your value. Your health, a healthy baby is not of more value in the eyes of God than a sick baby. A baby born genetically intact is not of more value to God or to the world; perhaps to society, perhaps to General Motors, if they want a healthy work force. So if they are sponsoring an insurance plan, the insurance plan may prioritise caring for healthy people and discharging the ones who are defective. But that is because big business is behind the insurance plan. That doesn't means that's morally correct or ethically correct. A government may chose to write policies that favour of having a healthy population because its more cost effective, they're tax payers, they'll be better soldiers. Napoleon couldn't get soldiers in parts of Europe because there was a iodine deficiency they were to many Kretans SO he didn't want his soldiers to come from this valley or that area. He'd happy to iodise that salt and have health policies that would make healthier foot soldiers for cannon fodder. The reason that the governments and the insurance companies and the big businesses, what motives them to decide who to offer care to and when to cut it off, is not necessarily what motivates the person who believes that we are all born equally valuable to God. And the suffering of a sick child is as wrong as the suffering of the CEO of General Motors. If he hurts and a baby with Down syndrome hurts, that hurt is just as bad and its just as important. It is not more important it relief the pain a wealthy man in a three piece suit than it is to relief the pain of a suffering child. So that kind of conviction will help me when I'm discussing or fighting for when I see a policy in place.

That is what I firmly believe. But that isn't always the way the policy makers and decision makers [see it]. They talk about whether its cost effective to do

mammograms to women in their 40s. Is it cost effective, OK? You can let that question go by, but then, wow, how did you decided what is the value of a life of a woman in her 40s? How did you calculate that? To decided that they would by so many dollars worth of mammograms to save so many years of life, how did you assign a value to that life. Is it economic value? How do you weigh? Some of those questions, if you push too hard you may not like to know who decided how valuable the life of a woman is!

You already talked about this, but the question that I have here is do you every find your personal conviction collide with your work as a physician?

Ok, when I owned the practice, up until three years ago, there weren't that many collisions because I could always fight for my patients, I could decide to see someone 'no charge'. It would hit me in the pocket book, I didn't make as much money. I could have set up the practice to make more money if I was interested in money I would never have seen public assistance patients. They're all a loss, I can't make money seeing public assistance, especially Medicare, medicaid). They're the poor, usually they're sicker and older, a lot of those decisions I could make when I owned the practice. And I made other decisions, not always the crisis case, but I would do things for the patients in our office, but I could have convinced them and send them away because I didn't make money to do it there, it took too much time, but I could always, I was free to make those decisions on behalf of my patients. And all it costs me was more stress on myself or less money or whatever.

Since I sold the practice, and especially in the last few month, with some different management policies, and the practice, its a long story, the practise if you want my perspective was not well managed. It wasn't managed the way I used to manage it when I managed it we made money and we saw everybody who came to the door, and we didn't alienate people, we were well thought of in the community, highly respected, if I must toot my own horn. ANd then we sold to the hospital and gradually, and all of a sudden quickly policies started changing, all the while our margin of profit we had the year we sold the practise is now the margin of loss. The practice is loosing as much money per year as we used to make.

So I was right, its no way to run a practice, the way they're doing it. They're squandering money, mismanaging, doing all kinds of big and small errors that have our practice now chaotic, loosing money by the truck loads, and now starting to initiate policies that I would never have allowed. Just this last week I was told I could not offer people free care or discounted care. I could not say to a woman, "ok, you're not poor enough to be qualified for medical assistance, you don't fall into the catch men area that we can off your this program or that program, you're kind of right on the border for this, your 2 \$ over for that. Well until last week I could say to her 'ok, you can come into the office, you need the care, you need to come in right now, I'd like to see you once a month, and I will charge you what you can afford. If you can pay half cost for visits until you get insurance, that's what I did.'" And I was told last week that I can't do that anymore.

SO your conviction that everybody is of value and everybody has the right to the same health care is rapidly collidig now that you're not in your own private practise anymore?

Right, the hospital, this is such a strange and confusing situation, because the hospital also gives away care, they are not adverse to it, as a matter of fact by law they have to. But there is no one at the helm that is close enough to the day to day operation of our little practice, and the other little practises that they bought, that understands that we the people who are eyeball to eyeball with the patients, need to have certain freedoms to give out care the way we see it has to be done in order bring the people into the system. We don't want barriers that administratively, that are written in an office far away that sound good on paper but when we work them out in the field they exclude people from care. Theoretically this woman could get care in a place ½ hour away. But she doesn't have a car, the real life is, yea she is over the border, and yea, there is system over there, but no she can't access it because this, this and this.. Besides which, iT took her a long time to have faith in me, took her a long time to open up, and we're getting somewhere, we're tackling real issues and this woman is making progress. And its not the right thing for her to dump her onto another doctor who doesn't know her and perhaps doesn't care for her as much as I do. I want to take care of that woman, and I don't care if I don't make any money, she should keep coming here. I don't want to be told, no, I can't discount her visit.

The same thing happened with a young man who is mentally ill, he hasn't hocked up with psychiatric services, he's facing jail time, he has no money for medicine, his family doesn't have money for medicine, they're living... When I told him to go down to the hospital to have an interview he asked his mother 'do we have enough gas in the car'? They don't have money to put gas in the car to go to the hospital that's 20 min away. NO money for medicine, he is in a pickle, but I'm not supposed discount his visit, I'm not supposed to give him a free visit. But of course I have to be able to. So those kinds of things are examples of my ethics colliding with a system, that is not an evil system its just an unresponsive system. The system doesn't want to be evil. The people who are making these decisions are thinking that no one is going to get hurt, they're thinking they're networks, there's way, if we rigidly say that we are only gonna take care of people in these boundaries, and we are gonna set up these policies, and if you don't fall in these guidelines or those you can't come her but they'll be some place else where you can go. But that isn't always true, they aren't always places to go, they can't get there, or for one reason or another its just not the right thing to do. SO those are the kinds of issues we're dealing with now.

If you hear Mennonite Medical Ethics, what would you see being included in that frameword? What kind of features would you priorities in this framework?

I think there has to be allowance for the individual to have access. I think that would be pretty, if we are talking about a frame of mind, or a point of view how I think most Mennonites would want to see the system work, it has to be based on individual value and individual responsibility. The relationship in community has to be paramount and for example, the doctor has to be morally responsible for his/her decisions. He/she can't be part of a big system that is faceless and nameless. We are a kingdom of priests, every believer is morally responsible before God, we don't believe that the church is a bunch of Indians with a couple of chiefs. We believe that we are all chiefs, we all have access to God, we all have the moral obligation to live out that in our day to day life. So there is no getting a doctor off the hock where the

ethics committee decided, in Mennonite ethics, I believe that doctor is still that patients advocate. The patient hired that doctor to be his advocate, whether he is an HMO doctor. (moral responsibility and moral integrity)

But One on one, we would built it into a system or assign it to a committee or we would think that a system can be morally appropriate. But we weren't into a church hierarchy or a church state, we didn't trust the state with out religion back in the 16th century. We believed that every Christian is responsible before God to live out their faith in their day to day life. And I think a Mennonite medical ethics should be that same kind of structure, the Mennonite doctor, nurse, therapist, practitioner is personally morally responsible and just can't say to the patient 'I'm sorry the system doesn't allow you to get chemotherapy, sorry, we don't have the money to save your baby'. While we might have to say that at this moment, we have not right to say 'and that's the way it's going to be.' We might have to say at this point in time I'm walking with you through this path, your child is as valuable as president Clinton's child. Your child is of infinite worth and my relationship with you is based on believing that. Just because you have no money, or that child has Down Syndrome or whatever, our work together us based on the belief that your child is very valuable and this system. This HMO is gonna pay your chemo, but lets work together, lets think of what other alternatives exist, never say to that patient, 'well I guess the cost benefit ration just came up and your short, you're 45 and not worth a lumpectomy', you're 65 you don't go to the ICU.' And just live with that. But while we maybe stuck with that, and maybe the answer for Friday afternoon is 'no can do right now, but come Monday morning, I'm going to make some calls, I'm going to do this or that, in other words, that relationship is not bound by the structures then the ethics we maybe not buy into.

Do you think Mennonite ethics offers particular approach in ways that another ethic is different?

I wouldn't wanna stereotype. Because, by all means, not every menno who was going to medical school was paying attention in Sunday school. Many of them have been very much influenced by pop culture and pop religion. So I think we got a lot of Mennonites who did catch the message of being a kingdom of priest, and being personally responsible to God and some of them may just not haven't gotten there yet, maybe they never will. We're on a journey and they are peddling as hard as they can just to keep up with the day to day pressures and maybe haven't stepped back to be reflective or haven't thought through their ethics or just go with the flow. Or they feel that the values we're talking about belong to a certain time period and now we're in the HMO era. And suddenly people are willing to relinquish, because of pressures on us, they are too easily ready to relinquish. They feel that they've been taught that they're supposed to, that the Professor in Medical school told them about the climate that we're practising now, they never thought they're supposed to challenge it, they were perhaps being. The med student kind of person very often was really the teacher's, did everything right, always coloured in the lines, studied for test, did all that stuff right, and now to challenge the system just maybe doesn't seem right. When the system sound like they are the proper authority until we look a little harder and steady until we realise there are ethical issues that are not being addressed, or they're being transgressed, and we didn't even realised it, it was like insidious.

And now, perhaps, for example in my personal case now, my job is on the line because I'm vocal. And I'm opposing what I think, some of it is system evil and some of it is just systemic boondoggling. But because I'm vocal, I'm actually being threatened with termination..... I was told to mend my ways by the end of the week, but I said, I'm on vacation this week. Ok that gives me two days to mend my ways, Thursday and Friday. But I didn't even get a clear listing of what my transgression were, so the whole thing is really a tempest in a teapot, and I hope it blows over because I do want to stay on the job in that location. Not even just for myself, well actually, right now its so stressful for myself, for self preservation the right thing might be to get up and go to greener pastures, walk away. But I have got a lot of patience who have trusted me with their health care and it wouldn't hurt me nearly as much to leave this wonderful people as it would truly be disruption in many of their lives. Many of these are old people who feel vulnerable, or sick people who feel vulnerable. And they have seen me as their advocate, and as their ally through many illnesses, I have taken care of lot of people for 20 years. So if I would suddenly disappear that would very upsetting, it would be a disruption in their lives. For some of these people the highlight of their month is to get dressed up to get the doctor. For people who have lost so much, a physician has to think long and hard before you just pick up and leave. Suppose I would say I'm making a statement, to give myself the satisfaction to take a stand, I can get a job, up the road, out of the area, I can't come back to the area for three years because they have this exclusion clause in my contract, but I feel like I have to try to work it out, for their sake and if things work out it is a good position for me, I want to stay there.

So, one last question: you are hired by a very good college that prepares students to go to medical school. And because of your experience as a physician you are asked to write their Medical ethical curriculum they want to put in place. Besides practical issue of medical ethics, what else would you put in?

I think one thing for example, that is just overlooked, I don't think we had any lectures on it, but maybe that it isn't overlooked now, see I'm out medical school 25 years, so I don't know what they're teaching now. But kind of how policy is written, how decisions are made. How does the government for example, write the preventive health guidelines? Who gets input in that? The insurance companies that come up with guidelines, on what are they based? When they talk about cost effectiveness, when they offer heart surgery to a child, cost effectiveness of the flue vaccines, cost effectiveness of mammograms, how do they analyse that data? Because that's pretty important, when they write a guideline it suddenly become standard of care and if you exceed that you are squandering medical resources and can be chastised in various ways. If you fall short of it then you don't practice up to the standard of care. But those standards help to define the care that people receive. I think people should not be naive, and understand what forces are at work. Interestingly enough the same people who rise to position of power and help to write our foreign policy, that allows us to drop bombs on civilian villages in El Salvador, the same people are in power and write policies that restrict access to medical care in our country. SO the same mind set that civilians are expendable in El Salvador, the same leaders, the same congress people who are willing to spend innocent lives a few thousand miles south of our border, they are not willing to see innocent people suffering in our borders?

423 Suddenly they have become so highly moral that they're decisions are based on the
424 highest moral principles? I don't believe that.

425 See, we never talked about that in medical school. But who funds the medical
426 school, where do they get there money, who gives money to the hospitals? There has
427 to be a moral voice that is not bought, and I nominate the church, because we can't
428 be bought, I hope we can't, we couldn't be bought. Sometimes we are co-opted, like
429 my church I grew up in was very patriotic, and to speak against dropping bombs on
430 civilians in El Salvador was just the wrong thing, that could not be said in our
431 church, but that's what's unique about for example the Anabaptist tradition. We
432 never were a state church, we're not a state church here either. The Anabaptists are
433 known for speaking out against slavery, long ago, against the unjust wars, against the
434 draft in the 1940s. So the Mennonite church has a bit of a unique position in being a
435 moral voice that has not been co-opted by patriotism. And the church I grew up in
436 has relinquished that kind of a role, we don't criticise the government or your
437 probably a communist, even in the year 2000 you're a suspect of being a suspect if
438 you criticise the dropping of bombs on children.

439 There are many issues that are addressed I believe, and that are appropriately
440 addressed, my daughter is in premed right now, and they are dealing with some
441 important med ethics issues. Obviously the abortion issue, and euthanasia have to be
442 talked about. and do I believe in certain settings they are. Its not like we have the
443 answers, its not like 'oh well if we would just teach our kids right we'd have all the
444 answers, we would spoon fed the answers, so when the got to medical school they
445 have all the answers and raise their hands. We don't have the answers but we need to
446 learn how to deal with those issues. Deal with them with a respect for all people,
447 whether you're pro-choice or pro-life, whether you're the foetus or the mother, that
448 all people deserve love and respect and all are created in the image of God. We're not
449 in a war, there's not an enemy. The Pro-choice people are not our enemies, we should
450 not be shooting them, we should not be insulting them, we should not be degrading
451 their position, we should be treating them with respect as Jesus would have. He
452 might have been emotional on one side or another, he might have surprised us by
453 being a hole lot more tolerant.

454 'There's a widenes in God's mercy, like the wideness of the sea. There is
455 kindness in his justice which is more than liberty.' We sing that song but then we're
456 very bigoted and intolerant, there's a wideness in his mercy but there's no wideness
457 in our mercy. We should teach a mindset towards these problems. We don't have the
458 answers, I don't expect to have all the answer, I expect to go to my grave never
459 figuring out some big ones. I don't think I'll ever gonna know how God feels like
460 about homosexuality, I don't think I'm gonna know, but I have to get comfortable
461 with not knowing.

462 I have to get comfortable with being around people who think they know, and
463 other people who don't know. We got to live together and tolerate each other. That
464 attitude of how to go about dealing with the issues, I don't think we need to teach the
465 answers, but teach how to work together to find the answers, and how to live together
466 when we don't know the answers. We are not very tolerant, I don't think we are not
467 doing very well on that, for the peace church to be at war, there will always be people
468 who feel very strongly they know the will of God. And maybe they do, maybe they're
469 right, but I don't feel that whether we are right or wrong, we have to learn how to

470 tolerate each other and how to live together and work together and treasure each
471 other. Not just tolerate each other, cause you can tolerate a broken leg, you can accept
472 each other but you cannot accept a tornado that hits your community. Acceptance is
473 not the final goal, it is to treasure each other. To treasure each other and to value each
474 other and to build each no matter where we are in the journey. And I believe
475 Mennonites are more committed to that than a hole lot other people, but I don' t think
476 we have figure out how that really works. We haven't figure out those kinds of
477 principles of explosive situations.
478 Well thank you.

1 Dr. Brandt, Canadian

2 > 15 years GP, 7 years psychiatrist,

3 . Brandon, Manitoba, Eden Mennonite Mental Health

4 . emphasis on non violence, justice, community, service, anti abortion, integration of
5 faith and life;

7 **You grew up Mennonite, right?**

8 Right.

9 **When you look back over life and the beginning of your medical career, I
10 assume you are a family physician?**

11 I was a family physician for 12 years, and for the last 6 years I've been doing
12 psychiatry.

13 **So when you look back over that career, are there any specific teachings of the
14 church that stand out formative to your choice of career?**

15 Well, my case is kind of unique, since I didn't really choose medicine as a
16 career at all, infact I did not even thought of it until highschool. And even then I
17 didn't even think of it. I just remember once in highschool, a friend of my father's
18 when we were driving to a church meeting, saying to me I got good marks I should
19 go into medicine, that sort of thinking. You're smart enough why not aim for the top.
20 I went to bible college, CMBC right after highschool, in my second year there, in fact
21 in my summer job, that's when I felt called into medicine. So that was pretty specific
22 thing, in that sense, it wasn't something gradually moved into. It was a pretty sudden
23 thing, this is what you're supposed to do sort of thing

24 But having said there, as far as teachings go, I think what I didn't learn,
25 largely at CMBC, somewhat in at least in a more formal sense and also in a public
26 part of my life growing up in a Mennonite community, the whole idea of community
27 I think influenced my choices in medicine and early practice. Because I wanted to go
28 into family practise, I was not interested in specialities, because I saw people in
29 groups and families and communities as whole, which I think related practically to
30 my teaching, my religious beliefs and the hole Anabaptist ideas of community. And
31 so the government at that time at that time was very keen on community clinics,
32 which are multidisciplinary, the doctors where on salaries, which was of course
33 totally opposed to the fee- for service capitalist enterprise idea of western medicine.
34 So, but that was fine with me, I was not in it for the money in the first place, and I
35 really wanted to go to a small town were I could get an idea of community and see
36 how health and medicine relates to the hole community, right. So I think that comes
37 back the teaching of community.

39 **So a strong focus on community, and also the experience of growing up in
40 community. Is there anything else besides community that stands out in your
41 memory that might have influence the choice from practitioner to psychiatry?**

42 Even in the GP part I think there would be some general influence of the
43 church which of course would not be unique to Anabaptists, that would be the idea of
44 mission and service, although that has certainly had been a strong area of
45 AB/Mennonite professional development, with teachers and nurses were the first
46 professions women went into for instance, and eventually medicine became one too.
47 So that when I went into practice I took the opportunity to work under certain service

48 areas. When I was a resident, I joined up with a program that delivered medicine to
49 Indian reserves up north, in fact I spend 2 summers doing it and in fact I enjoyed it so
50 much I went back for a 10 day Christmas spell when they were short staffed. And I
51 did that all through my years in family practice, I went to an Indian reserve to have a
52 clinic once a week. That certainly something I appreciate about the Canadian health
53 care system, with all the discussions we are having here, that you don't have to worry
54 about funding if you want to provide service to those people, its all covered, you just
55 do it. You can set up your clinic wherever you want and do what you want as long as
56 it falls into the regular scheme of practising medicine. It can be on a reserve or an
57 inner city, you still get totally funded by Medicare, whereas in the States you have to
58 get a special admission to do that.

59
60 **When you think back in you spiritual and theological development, is there any**
61 **place where you would put ethics? Is something that Mennonites talk about**
62 **separately, or is that something that falls in a similar category with something**
63 **else?**

64 Well, I can't separate myself from my Mennonite up- bringing and beliefs in
65 that sense, but I think ethics in some compartmentalised sense will have importance
66 to me, in areas like anti abortion or euthanasia, or all those compartmentalised areas
67 where your beliefs might play a role. I've been involved in supporting and being on
68 the board and that kind of thing in Brandon, MB there is a thing called Pregnancy
69 Distress service, which like a support for unwed mothers and girls that were pregnant
70 by mistake and all that. Which is very interesting because most of the Mennonites
71 and the Catholics that were behind that. 400 years ago they were enemies but now
72 they are on the same wave length.

73 And now that I'm getting into psychiatry, or am in psychiatry, I should say,
74 one area where I find I struggle with it, its not just a personal bend, I don't think, I think
75 there is more truth to that, and I'm struggling with it and trying to come to grips with
76 it, to put words around it and I'm trying in sessions like this to get into discussions
77 with different people, who might have different ideas about it from their own
78 pilgrimages, is the whole idea of non-resistance and force. You can see where that
79 comes into psychiatry, behaviour programs. Now, behaviour programs by themselves
80 are fine of course, no problem, you have voluntary clients doing that. But when you
81 have inpatient setting, and then you have people come into the hospital who get
82 admitted, for one reason or another they end up on a behaviour program, which they
83 really don't have a lot of choice about being in when they are on an in patient
84 program. And some of them will object to the point that they'll leave the hospital.
85 That means the that they are being denied treatment, care, and I certainly have some
86 difficulty with it, in fact I was trying to write some stuff down last night. Behaviour
87 programs does not involve compassion, you know "you do this you get this reward or
88 this consequence", that's about it. And I think this might get a little off topic, but I
89 think our mental health system which I think is the same in the UK, and North
90 America, the moral treatment, it started after that, the big institutions. Psychiatrist
91 where scars and people who were really trained, in the 1950-1970 in Canada, who
92 retrained in psychiatry were scars in that system. So the leadership got taken over by
93 social workers and psychologists, none of whom were really clinically trained. Social
94 workers did case management stuff, and psychologists did test, but they weren't

even clinical psychology to had training in psychotherapy, so they didn't have much of training of care and compassion. So they designed all these hospital programs, and this is were the state run institution are still going with those sort of idea. In our situation in Brandon, its no longer a state institution, its brought into regular wards, but our staff most of them grew up in this era, and they still run that way. And I constantly keep getting into [problems]. I don't make a case or a conflict of it, yet, I mean I'm only in the system 6 years. But in my own head I'm constantly log a lot of that stuff that's going on. You you're trying to be team player, but you get the kids complaining about the program, and privileges but then 'well we as a team' but really in my head I would do it differently. But I'm not sure how much of that is am I just a softy, you know personality wise, I know I am somewhat. But is that or is it part of being a compassionate, caring physician to be a softy. When it come to my own kids of course I have expectations and limits so I would have for these kids the same, no less. But so that hole area, what does non-resistance and non-violence say about that, forcing people to do certain things.

The worst of it is they have both for the adults and the kids they have these programs, I don't know how wide spread they are, the call it 'time out life style'. Personality disorder people come back to the hospital, so staff get kind of tired of it. Well, partly its getting kind of tired of it, for sure they are, but partly they also rationalise and its often a justification, they say, this person has to learn to cope, so we develop this system. If they comma in again and again, and at the third time, under these circumstance, same history, then they put them on these time out life style program. Which means "you go into the room and you stay there and you work your way out." And the thing happens with kids, if you had enough infractions over a period of time, and enough consequences, than they end up on that program. Those are kids, 12 years old, they're stuck in their room, and they have to work their way out. They have to figure out how to get out there. Now what do I have to do to get out of here? Well, to be goo basically. Now what does that teach you? Teaches you to get out of your room, but in the long run?

You've answered a little bit of the one question here. Can you tell me about times when your internal ethics and theology collided with your medical code of practice? And I hear you say that you ask what's compassion got to do with this, what's non-resistance got to do with this?

Well, now this is not exactly so much ethics, maybe it could be talked about in terms of ethics, but more just compassion, relationships all that sort of thing. In psychiatry especially, because of its nature, which of course true for other areas as well, is t the sort of the concept of boundary, which psychiatry makes a lot of for good reason of course, because of the sexual things. But then again, I see all these patients of mine, who I know in my heart of hearts, sure if they would really be in the right relationship with God, however God might be defined for them, they could avail themselves of a lot, have more inner peace, the might even get some resources and strength to resolve some issues that they're not resolving in their lives. But I struggle with were do I cross that boundary, not so much its a problem to you a cliched word 'witness in the office', although I do that very limitedly too. But again, there the profession would teach you you can't sort of do that, because then you use your authority, your power, then you have undue influence on a person. If you tell

your little patient he/she should be a Christian, then that's not fair. But even not doing that necessarily, but inviting them to you own church, as opposed to some other church, I try and encourage them to go to any church, but then inviting them to your own church, that's a little more iffy altogether, right. I remember reading a psychiatric journal cause there is a lot more discussion lately about religion and spirituality, and this person saying that in the states where there was this Christian psychiatry movement where they worship in the same churches as their patients. Whereas the rest of psychiatry would frown on, that would be like a boundary infringement, right? That sort of thing. we don't often think about it in terms of ethics, but its still a question. It would be falling under professional ethics, that undo influence kind of thing, the power difference.

On the other hand as a Mennonite, with that faith history, you wouldn't probably say its not necessarily as a problem because in the eyes of God we all are the same, no matter what problems we have.

Sure, that's true, yea, and there is certainly part of that influence, its that whole idea that we are all made in the image of God. I always think of that when I see "patients", I mean they're people just like me, right? And you can be friends with them, but again there too, how much can you be friends with patients. Some of them call me, or would consider me a friend, even though we are still doctor-patient, we are not socially friend in the sense. But you know, once in a while you cross it, its with all physicians, compassion runs into it, end up offering them a ride home when you're the last one together in a cold rigid day. And you know they'll walk and you're driving off in your car.

So, you said, compassion, non-violence, those are the thing you would consider ethical theological teachings of the church? Are they theological or are they ethical? Anything else you identify as particular Anabaptist teachings?

I think the hole issue of community in a different sense than I was talking about before. Maybe as opposed to the hierarchical church? I see that coming over into my practice too, where it some of my life experience and comes from my beliefs in that sense, that you don't necessarily look at all these level of burocrasts and government agencies and power structures, you don't necessarily give them the same respect, and I don't say that in a negative sense, that you would having grown up in a different background. If you consider all equal, in some ways why should what they say have any more weight than what you say, like what they want to justify as what you belief. So when it comes to working in systems, in bureaucracies, I think my Anabaptist beliefs there would influence that I would not be as worried about crossing those kinds of lines to communicate with people to get things done. And when I do see people that kind of put stock into their position, and I see them even as Mennonites, that rubs me the wrong way. We had a prominent Mennonite who was a Deputy Minister of health for a while in MB, and he'd been active in MCC overseas. I've been at the same banquet table with him, for instance, he didn't give me the time of the day. Like what does that say, you know? Not that I want to push my weight around, but I'm not nobody, even if I was nobody, why shouldn't he talk to me? This was a fund-raising dinner for Eden Mental Health service, you know what I mean.

I was on the board for Eden Mental Health Centre for several years, its great you had lay people, professionals, doctors, pastors, whatever all on them same board. I think they try to work together a lot more as a team, as a hole organisation not having a hierarchical structure that carried weight by its own force. Whereas secular system would be like that.

You talked earlier about when your Mennonite ethics questions come up, like were is the compassion here, or where is the non-violence? Do you think of practical examples when your work is influence by theology and ethics?

Real practical sort of situations, day to day. Well a larger one that comes to mind, is related to the non-violence too of course, is the increasing militancy of the health care professions, even doctors now , of going on strike sometimes. I don't believe that, I shouldn't do that. I don't think that's an AB teaching to go on strike, and use that much force to kind of persuade somebody. At least that's not the way Hersberger and those guys would not write this to be good procedure. And yet its come close sometimes, very, very close sometimes, but I've been fortunate not to have to do it. But that's a little bit removed from the everyday.

Maybe in psychiatry its not as prominent as in the work of a OBGyn or GP, like issue where you clearly see this is colliding with what I believe as a Christian. But I am this bind that I have a professional code of ethics to follow, but still don't think this is right?

I can think of one for instance, in family practice, doesn't cross my path so much nowadays. But the hole issue of young girls and contraception. I mean I don't believe in premarital sex, but what do you do then when you have young girls who are active, you know they are coming in and they don't to get pregnant, you don't want them to get pregnant. I did, I must admit that I did give contraceptives in those situations most of the times when I was in general practice. That would be called a compromise in a sense because my belief is that it is wrong to be engaging, but of course I can't tell them what to do, they're not even Christians, so they're doing it. But then am I compromising my faith and my stand, my purity if you will, or belief and practice by doing it? They already made a decision to be sexually active, they don't want to be pregnant, is it wrong for me to allow that to happen?

It certainly became a different situation when it came to abortion, I don't believe, there are some Christian physicians, catholic physicians, somebody mentioned they didn't want to be pregnant, they barely even begin to talk about the idea of abortion, and the doctor was showing them the door. That was it, I don't call that compassion. This person is suffering, something happened, they didn't want it to happen, maybe because of an action they shouldn't have engaging in to begin with, but they got themselves into a situation. But again, is it compromise? What are your choices, you have a choice being like that doctor, not even to hear about it. You have a choice of saying you could go and see this doctor knowing full well this one is going to OK it probably, so is that any better? Or actually referring them to a clinic? I don't know, I can remember about three or four situations in my career when I came up against that question. But when I first went to the family practice in Brandon, I was as part of my service idea, they have public health clinics where the girls come for pap tests, contraception and all the rest of it. And I helped out there, a lot of them

where students, but eventually I had to quit. I just didn't feel good that I was supporting something that was ended up being planned parenthood of public health. You could say, kind of condoning a life style, you know when it came to the individual patient of mine, I could talk about it, where overhere, you were there to do it, you weren't there to tell them not to, you know what I mean., that sort of thing.

So that's a pretty strong collision of you conviction

I quit, I wrote a letter of resignation and I quit, doing that in that setting, you know.

Did you at that point think that there was a connection between your theology and ethical conviction? Is it too far fetched to say theology and ethics are two different things, or do they influence each other somehow?

I think you're theology would influence your ethics, for sure as a Christian, I cannot see how it wouldn't. It think that's not just Mennonites, that would be Christians in general. Because, I don't see how ethics can exist without some value system behind them. Nowadays it is been moved farther and farther away from that, all those hospital ethics committees, sometimes I think they just in some instances they are more based on economics. Should this person have some more life extending treatment of not, its almost more economical than compassion or something that would be linking more back to theology that way. Decisions about treating somebody with a swallowing problem after stroke, like that consultation I had once. If you can't swallow food or anything you're not going to live, right? If I remember right, he and/or his family there was a conflict between them who didn't want to do anything about it. I don't remember what happended in the end whether he got a feeding tube or something. You could make those kinds of decision based on economics like rationing of resources? well is that ethics? couldn't, but then that's pretty far away from theology.

When you think of developing a framework for Mennonite Medical ethics what kind of features would you include?

Of the top of my head without any research, some of the theological beliefs we have about servanthood, and community. With what servanthood and community have to say about equality, sermon of the mount, the greatest being the least and the least the greatest, some of those kinds of ideas. Following the sermon on the mount which AB have followed more than other groups have, should be part of that. I think there would be all kinds of ramifications for community, but some of these decisions, what's best for the community? How do you define community? Is it just family, is it larger than that? Some of these decisions which now a days society makes so individualistic, lots of them gotten away a long way to see what is best from the community perspective.

And then the non-resistance, non-violence aspect could have a lot of influence to make on some of theses decisions. Like forcing people to live longer by doing some intervention, something like that. Decisions of competency, some of those kinds of things, does community enter into that? Just when it comes to resources too, ideas about communities could have a lot say about use resource instead of just individualism, obviously. And then servanthood that would have a lot to do with the attitude with which we do things, how the structure should be, I think. Those are few

things I can think off hand that are more unique to the AB/Mennonite theology as opposed to other theologies or Christian theology in general.

I mean I think the code of conduct ethics that is there, traditional ethics is not a problem, Hippocratic oath, that type of thing, that's not the problem. In fact now, there is a society formed in Canada called the Society for Hippocratic Medicine, was formed under the auspices of the CMDS, which is really interesting, because you think this is the Christian medical Society, what are they doing promoting Hipocrates? I'm not sure they have thought through the theology entirely, what is it is basically to keep alive the Hippocratic aspect of the oath that says 'do no harm'. Especially for the things like euthanasia, child birth thing, unwanted pregnancies, that kind of thing. They are promoting that kind of thing under that society's auspices.

I can think of other Christian things, not necessarily only AB, such as God give lives and God creates life but that influences your decisions. It says to me I don't have the power to make some decisions what other people think they're taking into their hands about life and death. But that's not uniquely Mennonite or Anabaptist.

Included in the stewardship question it might take a different slant than a Presbyterian understanding and might have a different outcome?

Maybe a little more emphasis on equal sharing and distribution. I think that the whole idea, then again the AB various aspects of theology will have a strong influence on the other Christian groups. The idea that we should be giving health care to everybody. For us in Canada is very nice to work in a system that espouses that at least theoretically. Whereas in the States I would think, you know you're constantly faced with, and I'm sure that's why we have the discussions here, and our brothers and sisters in the States struggle with that more and more, they're finding it more and more difficult to practice when they see so many people being denied what other people have.

Some other societies in the present and the past, the class system was sort of accepted, your gaining what you got, its not as overt anymore but its still there in some societies, some groups, some religious ones too. Some religious groups too don't see the problems as much as we do with the emphasis on equality, servanthood, and equal sharing of resources. Why should anybody be entitled to anything more than anybody else?

Lets have a little scenario: you're called by the president of CMBC to develop a curriculum for medical ethics for college students. What would be the things that would be important for you to put in there?

Well all those things we've talked about, like looking at being more open to your patients as people, the whole boundary issues could be discussed and looked at, and maybe that changes that attitude over time. The idea that we need to do this not only as a profession to earn money but also as a service, and that money shouldn't be there for our main objective either, but that has a lot of bearing on a lot of the politics for negotiating fees and contracts and how medicine is run, relationship to government, fee-for service.

The community part of it, to see not only the individual in front of you but how they relate to a larger community. The whole question of non-violence and non-resistance would be interesting one to tackle with some of the issues about decisions

about treatment, fees, consent, competency. Even and this isn't unique but as a Christian principle, what does it mean to believe being made in the image of God and how that influence our view of decisions. Also the role of work in our life, that's something we struggle with all the time, our community and family and other needs in life besides just our work. CMDS is always trying to address that too from students on.

And I think maybe Anabaptist too is, that's an area we have not talked about at all, I think the real Anabaptist going back to 16th century, especially when it got into Holland, there was that strict tolerance. You know the Netherlands is certainly the hub for tolerance, they've gone way overboard nowadays, I think. But that we don't just jump on all kinds of alternative medicines, nobody has all the answers, and I think we need to be open to those kinds of things. We know what really works in healing is faith and the person, trust, the relationship is a big part of it, right? Whatever you do, whether its vitamins or Ginkgo or whatever, all that might be kind of minor in the faith relation. So I think tolerance is kind of not being judgmental, especially the right wing. Lot of Mennonites who don't know their heritage theologically, are pretty intolerant, those who totally support the Reform Party. Whereas its interesting, the other side of Mennonites, the ones that have more education, understand their heritage better. I'm not sure you've become aware of this, there is a real split where there are some who support the New Democratic Party and their cabinet ministers and the New Democratic government, and everything. There is a Mennonite minister in the New Democratic Party. But then you got the majority would probably support the Reform party. So the idea of community, this real idea of community, sharing resources, nobody being better than anybody else, that is not that much different than some aspect of Socialism or Communism, early church Acts, sermon on the mount, that type of theology, you know.. And some of the revolutionary catholics too.

I think its interesting that you pick up on the tolerance question, even religious tolerance.

Yea and the separation of church and state, even in terms of practice. You know like with using the resources, we're talking midwives now being trained and funded and all, which I think is fine. But you could broaden that and why doesn't the government fund psychologists to do therapy too, why not, the more people the better, of course there's a hole lot money involved. As long as there's some standards and changing, you know, that sort of thing. There could be all kinds of specialists that could maybe support that route.

When I was in family practise, one old lady who had breast cancer, metastatic, well she knew she was going to die, she knew it. She came back into hospital again, and you know between here and family and staff we decided would not give her anything. So she was gone in three days. I mean when you withhold fluids, most people go in three days. Then I had young doctor come in to join us, just graduated from surgery, of course they can be a bit more action oriented and all that. He was appalled that we did that stuff, he wasn't a Christian. But to him that was just unethical that we would that sort of thing happen. I don't want to call it euthanasia, I just call it nature take its course, or God, or what you say. He did make a point that you have to be, of course we didn't withhold things actively, she could drink all she

376 wanted, we didn't give her an IV, because an IV would just have prolonged it a little
377 more, not a lot more. But do have to be compassionate there too, and try and give
378 them something for pain, because to die of dehydration is pretty awful as well.
379
380 Well thank you very much.

1 Dr. Joseph J. Duerksen, KS

2 > GP, General Anaesthesia,

3 > grew up in India, 15 years of service in India,

4 > emphasis on non-violence, CO, simple life, following Jesus teaching in life,
5 abortion supported but never performed, interesting view on sterilisation programs in
6 India,

7 > evangelistic understanding unique,

8 > most informed about medical ethics, been on ethics boards at KS State University;

9 . thinks medical ethics well developed for support of all religious communities;

10 - does not see the need for MME, but sees Mennonite theology coming to bear on
11 support for individual in spiritual crisis;

12
13 **I assume that you grew up Mennonite?**

14 Yes.

15 **Family background: Mennonite forever?**

16 Yes.

17 **When you look back over your upbringing, and your life and career, do you**
18 **recall any teaching of the church that kind of paved the way, so to speak, for**
19 **you to choose this career?**

20
21 Well actually I suppose my situation was somewhat unique, my parents where
22 missionaries in India. So I grew up in India. And uh, essentially I had most of my
23 education through in highschool, at a missionary school, Woodstock. So that had a
24 large group of missionary kids at that time, Methodist, Presbyterian Baptist, disciples
25 of Christ, and a few little scattering of Mennonites. But I'm not sure actually other
26 than probably reading one of this romanced novels, missionary novels, I suppose,
27 about 12 or 13, it was called *Johnny's Crutch*.

28 So this was set in Africa, in the colonial days, this particular kid who grew up
29 in a family (where) his father was been cited with the Victorian cross, stuff like that,
30 big stuff. So anyhow this kid ended up going to Africa, as a doctor. Now, why this
31 particular book sort of struck a note I'm not sure. But I can still remember as a real
32 little kid, you know, somewhere before the age of 7 or so, we were located in a rather
33 isolated town, Corba, and Dad, you know, even though he wasn't a doctor, and he
34 would be assigned things, my mother would help him with things like lancing boils
35 you know, and stuff like that. This is probably pre-antibiotic era.

36 And I could still remember we kids went over there one time and somebody
37 had been mauled by a leopard, I don't know whether the fellow made it or not. But I
38 can still remember looking at the sheets on the bed when he came in, with a hole
39 bunch of dried blood and stuff, and apparently the fellow had been very badly mauled
40 (?), and that left quite an impression. So, before coming to India my mother had a
41 little bit of nurses training, essentially she was a teacher, and had a little bit of nurses
42 training, and the missionaries at that time were courageous people, they did what they
43 could for whatever the situation was. Then there was also a nurse up there by the
44 name of Augusta Schmidt, who also later on I guess came to that particular station.
45 So I guess these were the original sources of interest. So anyhow I resolved after
46 reading that book that I was going to go to Africa.

Well it became pretty obvious after I grew up a little further, there was no particular reason to go to Africa, there plenty left around in India to do. So I supposed that was sort of the beginning of my career, whether, actually the folks (this is later on) they transferred down to Jangishpoor. And Jangishpoor had a hospital; fellow by the name of Dr. Dester, had come out there and establish a hospital back in about 1927/28. So he heard that I wanted to be doctor, so he said fine: "we will check that out, you wanna work in the hospital during your vacations from highschool." I said, "oh yeah". SO I was a funky in the pharmacy, had to wash the bottles you know, and had to clean the place up, and I had to mix the ointments you know, and all that kind of stuff.

But then, the advantage of that was that I also got to go in and watch Dr. Dester to do surgeries. So theses were sort of the beginnings, but by that time you know, I had pretty well decided that I wanted to become a physician. And whether this had any distinctive connections to Anabaptism, I have not the slightest idea.

There was one interesting thing, having grown up during the war, the WW II, everything was very militaristic you know, everybody was expected to go into the armed forces, and so on and so forth. And being in this Methodist/Presbyterian Christian environment, there was very little of anything that had to do with pacifism and so on. Probably with the exception of the highschool scripture teacher who happened to be a Methodist, by the name of Scott. And Scott in the course of his teaching us the senior, well what would we call that, the senior scripture class or whatever it was you know, discussed ethics to a point you know it raised questions about lot of things. And it was interesting that somehow I had this feeling that there was something different. Now whether my parents gave that to me in subtle ways or I don't know what. But there was another missionary girl who belonged to the Christian Missionary alliance. SO we were sort of were involved with the Christian endeavour meetings. We actually raised to the hole question of pacifism, (**oh wow, the two of you?**) the two of us. And that was what, the only 2 of us that had had any connection at all with any kind AB type of background and raising question about militarism. So as a senior we actually raised the question.

So I mean the hole Mennonite Theology thing kind of was picked up by you more by modelling from your parents rather than by teaching?

I would imagining, there was quite the subtleties that came in through there, and then you know for instance this fellow, this Methodist by the name if Scott, he raised the question about accepting all ethics you know, all standards, at that time of course, everything, because any dead Jap was the only good Jap. And the only good German was a dead German you see, and than that philosophy permeated our entire bringing-up, you see.

So the athletic field was called after Hansen. Hansen had shoot down 25 (sirrows) before he was finally downed and killed. SO he was a big hero, you see. So that was sort of the way it was. With this unsettling sort of feeling that I probably could go along with what had happened. Dad was Consciencious Objector in WW I, and he related a couple episodes and whether he ever did that to me, whether he ever related that to me, I don't know, whether ever related that to me or not. And we had other missionaries, Harrold Razlaf's for instance, who is a strong Consiencious Objector who came out as a young missionary. So I'm sure I picked up things from these people.

94
95 **2. If you think back now over Mennonite theology, what would you say are the**
96 **important teachings of Mennonite at the moment, or I mean in general?**
97 (just thinking about the entire picture?) Yes.

98 Probably #1 is that the teachings of Christ went far beyond anything you
99 know that we would normally consider as guiding principles. Taking the Sermon on
100 the Mount for instance seriously, has a lot to do you know with how you approach
101 things in general; political things, way of life, ethics, moral principles. And if as
102 followers of Christ we are at all serious then we take very seriously words. And not
103 only that but you saw that those lived out in reality in Christ's life.

104 **So its not just something that you would say that we would teach in church, but**
105 **it taught it also has to become practical?**

106 SO its not just a series of doctrines, 1-7. But then you would say lets say, the
107 simple life. What does a simple life really involve? How does that influence the way
108 you function in terms how you handle the income you get? When you have to pay
109 taxes, and you're basically forced to pay taxes, how could you escape as far as
110 possible the taxes that comes? So, because you know very well that the taxes that you
111 pay had ended up killing people in Vietnam, and in Iraq, and all over the place. We
112 life in a militaristic society. So you sometimes look at that and you say well if you
113 don't pay the taxes, you gonna end up in prison, or they'll come and take the tax in
114 money anyhow. And so there were little things like contributing right along, you
115 know, deferring more deduction and making those contributions up-front. So by the
116 time you came to the end of the year, you'd actually donated more than the taxes. So
117 when you pay to Caesar, you'd actually paid Caesar less then you paid God. So you
118 knew that other aspect went, so instead of having big deductions taken, and the
119 government using those for a hole year, you deducted a greater portion and
120 contributed that. So this is just a practical way of making contributions for the things
121 you really wanted to contribute to which lessen what you have to pay to the
122 government. SO you took it in a very practical sort of way, like to figure out who you
123 could do this.

124 And you know, being a physician, there is nothing you can do, to live below
125 the level of taxable level is actually not a reality. If you worked in a group you got
126 paid a salary. So what do you do with this salary? So, the simple life than involved a
127 simple life style, simple living quarters, you life in a house, that is no different than
128 probably the middle class, lower middle class, well you know I mean, three bedroom
129 house. Its quite adequate. But the idea of building a new house and spending huge
130 amounts of money you see, isn't really compatible with the teachings of Jesus. So,
131 you know, those are some of the things.

132
133 **4. So when you look back over your own spiritual, theology faith development,**
134 **where in that, on that whole spectrum would you place ethics? Is ethics**
135 **something that comes with theology or with faith, or is ethics something that you**
136 **just talked about 'you do'? Or is ethics something that you can separate out and**
137 **talk about separately, without any connection with theology? Or where would**
138 **you put that?**

139 Well I think theology, the question of theology resolves itself in ethical standards and
140 certain ethical behaviour. So I think it starts there. So all the rest of the ethics that we

141 discuss, end of life issues, and all that kind of things, you see, which are considered
 142 medical ethics, and all the principles of what shall we say, proper behaviour, you
 143 know towards patients relatives and so on, **(doctor-patient relationship, things like**
 144 **that?)**. Yes, those are all sort of judged on the basis of what you would expect to be
 145 the teachings of Christ as applied to us. So end of life issues, you know, you think of
 146 those in terms of theology. Things like some of the major issues, abortion and so on,
 147 you know, you think of those in terms of basically as sacredness of life. But by the
 148 same token you're disturbed them by certain situation that really are devastating.

149 You take a child whom they can now diagnose as having non-compatible
 150 defects, and under those circumstances the question is do you bring such a child into
 151 the world, where you know very well, there is nothing you can do about it? There you
 152 know, you raise a question whether abortion is not a valid thing. Or in some cases
 153 where the defects are diagnosed later on, and they getting incompatible with life, the
 154 question is why do you deliver that child into a situation where nothing can be done?
 155 When then you lay all that, all the guilt and pressure on the family and society and so
 156 on. So it raises very though questions.

157 And I have a friend who probably does all the very complicated sorts of late
 158 abortions, late in pregnancy. And he feels very committed to helping out with that
 159 situation. But that really raises a bunch of really tough questions. And I haven't had
 160 to really deal with helping people make those decisions. But as an anaesthesiologist
 161 you know, you run into some things that are rather difficult situations.

162
 163 **(Would you be able to highlight besides simple living, and like those kinds of**
 164 **issues, would you be able to highlight any other ethical teachings of the church,**
 165 **of the Mennonite church in general? Or Anabaptist theology in general, that**
 166 **come to your mind? Maybe first just in general and then the ones that are**
 167 **important to you?**
 168

169 The ones that make us Distinctive, because we had to deal with that a lot,
 170 what makes us distinctive form any other Christian group. And the fact that our
 171 theology and our ethics grew out of the reading of the NT, and where the reading of
 172 the NT is done with any serious intent, amazingly, people arrive at the same
 173 conclusions. So lets take the one that's usually the one that presents our hole
 174 theology. So the case of non-resistance, this is one that always comes up. And having
 175 come through, well, actually I registered in 1945, so the war was just over. So by the
 176 time anything came, actually I registered as Conscientious Objector, and so by the
 177 time the next drafting came along I was already in college. So they deferred all the
 178 college students. Then I went down into medical college at Kansas University and
 179 about that time the Korean war came on. So this is very interesting, because there
 180 were a number of us Mennonites at Kansas University, probably about 6 or 7. And so
 181 the rumour came on, came around that they were going to make all of us join ROTC,
 182 Reserve Officers Training Core. SO the rumour was that since the war is on they
 183 were going to need officers and so on, they were going to make this compulsory. SO
 184 we wrote a letter, all of us signed it, we wrote a letter to the chancellor and we said
 185 we're Mennonites, we're Conscientious Objectors, and we simple can't go along
 186 with becoming members of ROTC. And if this a compulsory thing, than I guess it
 187 means that we have to drop out of school. So this was move we made. **That's very**

188 **gusty.** Yea, and we got a letter back from the chancellor that said, naw, that's just a
189 rumour, don't worry about it.

190 SO then we were in medical college, you see. So finishing medical college,
191 but that time the Korean war quit to. And at that time everybody was trying to get
192 there compulsory service out of the way. So, during my internship the most common
193 question was, what branch of the service are you going to go into. So in other words,
194 get into the service, get your 2 years done, get out before another war brakes loose.
195 So, in all honesty, I would have to say, "no branch of the service." Than they say:
196 "What? No branch of the service? How come? What kind of thing is this?" then I tell
197 them I was Conscientious Objector. So then the fun would begin. One fellow who
198 was gung-ho navy for instance, when I said "I'm not going into any kind of the
199 service." He said: "Why?" I said: "I'm Conscientious Objector." He said: "A what?"
200 "Yes, I said a Conscientious Objector." And I said: "I have an objection to go into the
201 armed forced, taking part in the military. And he looked (can't understand from
202 wind) he said: "That's it." And he was a senior fellow, he was a resident already. And
203 I thought, oh boy, here we're going to have trouble. It was just as though we had
204 never had the conversation. We continued just like we had before, he never the raised
205 the issue again.

206 On the other hand, the was another fellow. We were sitting late a night on
207 time, and nothing was happening on the service, so he asked the same question, so
208 we got into it. And that fellow grilled me mercilessly. I think the hole conversation
209 took three hours. He would say 'what would you do under this circumstances', "what
210 would you do under that circumstances", and this went on and on in a very hostile
211 sort of way. I answered what I could, I've never been in those situations, I would
212 hope that what I have thought about before would be something that I would act on
213 when the time comes. If I have never thought about it, I'm sure I would react in a
214 perfectly non-Christian manner. So if somebody came I would shoot them or they'd
215 shoot me first and so on. So is said "I can't really say , because I've never been faced
216 with that issue." So after we'd been talking for several hours, he all of a sudden
217 became very quiet. He said: "You know, I have something that's really been
218 bothering me. I was a fighter pilot in North Africa and you know, we went on all
219 our sorties, we bombed and we strafed and all that kind of thing, he says. And on
220 days when we didn't have an organised sorty we were allowed to go up in twos and
221 just hunt, see what we could find. So he said there was a boat going across from the
222 coast of Italy to an island. We knew that on that island there was a German garrison,
223 and they had radar on that island, early radar, so we knew they had that. This launch
224 was filled with people, we couldn't tell whether it was a military launch or whether it
225 had enough military people on or not. So he said: "We kind'a circled around and sort
226 of debated this thing up in the air." And then either he or his buddy went down to
227 check it out. And came back up and they were still uncertain as to what the score
228 was. Then they thought, "well, we'll shoot it up anyhow." So they went down and
229 they strafed that launch and left it disabled in the water with all these people on board
230 between the Italian coast and that island. They had no idea whether they shot up
231 military personnel, or whether there had been any military personal on it, but they
232 had absolutely destroyed it and left it in flames down there. He said: "I have never
233 gotten over that." **(Wow! Because they didn't know how was on there)** They had

killed people indiscriminately, just because a target was there. And this is a common, this is a common type of activity.

So you know, lots of things would come out at the end of these discussions, and during the course of these discussions. There were fellows, military fellows, who would say for instance, "as we drove along in Europe with refugees, the Germans on the side of the road, running away and so on, sometimes we'd just wrecked our truck over to the side and crush a bunch of them." So it was no surprise when Milay came out, you see, during the Vietnam war, when all sorts of people where uselessly killed, civilians where killed. There was this tremendous cry to defend Kali. The cry probably came from Americans of the W.W II ear in Korea, who knew they had killed civilians and so on. And why should this fellow now be punished severely, you see, by the very military which had taught him to kill. So lots of questions like that came up and then Vietnam the same. They always raised the question of the resistance to the Vietnam war. And you sort of have to stand up periodically defend the resisters. And one of my good friend had been Korea, oh I guess in Vietnam actually, guess it was in Vietnam earlier. And he would say, and he had only derogatory comments for these people, but we had already been in India for 6 years and we were back, I was doing some further training at Kansas University - but he said "well you're OK, I know yours a genuine feeling about it." So you know its kind of interesting to see that. But all along you know, you had to sort of stand up for that, it was very uncomfortable.

So you say non-resistance and the peace stance is a characteristic of Anabaptist theology and ethics?

That is a very distinctive thing, you see. You know, do you obey the government above God? And that devise, that is a dividing sort of thing.

Are there any other teachings that you would consider like characteristic besides peace and non-violence that like Mennonites are known for (besides like cookbooks and dresses?)

Some of the things were distinctive way back, you know, at the beginning of the era, you know. The state church, then the theology of the state church being sort of part and partial of both the state and Christendom. Anabaptists declaring that this was not so, so the infant baptism and that type of thing. But you know if you grew older and you saw lots of things changing within the Protestant ethos, you know: so the Methodists baptise their kids and then they confirm them when they've come of age, and we bless the kids and baptise them when they come of age. So in all reality there is not difference. But the sacraments, there is nothing magical about the sacraments. They have their value, they have tremendous value, but there is nothing that magically saves people and so. When we ended up in India for 12 years so we ran into the Hindu culture there. **(That's a whole different issue that you have to deal with).**

Oh, yes, and then you get into things like, you know like 'at what point do you just cram 10 theological points down somebody's throat, and then call them Christian. So you know you would, you might have operated on a patient that had cancer you immediately see they wouldn't get better. So, what do you do? So every once in a while if the situation was appropriate, you use sort of an analogy that they could also understand. And you might say something like 'you grew up a Hindu and I

grew up a Christian, and chances are I'm not going to see you again. But when it comes to crossing the river, there is one person who can get you across, take you across and take me across, so just remember the name of Jesus. Because he can take you across'. And you're a Hindu, you know, you knew very well that you have no business of cramming a bunch of theology down their throat. But there is nothing to say that Jesus Christ couldn't take that that Hindu across.

4. When you think over your medical Practice as an anaesthesiologist/ surgeon, right?

Well I did 15 years of General Practise and surgery and practise and then switched over. **Where have you encountered your Mennonite ethics in work anywhere in a positive way or maybe in more a confrontational way? Maybe there was a situation where you say, 'ok, this is my medical code of ethics I need to do', but you have like 500 red lights going off in your head saying 'ok, peace, justice, non-resistance', you know like the hole things goes down?**

Thinking back of some interesting situations in India, for instance. You know, you might have a kid with a congenital anomaly come. In one case it was a child which for instance had extra, bladder hadn't formed. So for instance, you would say to that patient, to the family, you would say, you know, "the only way we correct this deformity is with a large series of operations. One to do this, and one to do that, and another one to do that, and another one to do that. And if you chose, if you choose to do that, you know, have us work on this child, this may take a considerable period of time, and be very expensive. And as far as the hospital is concerned, you know, we would probably do a good portion of this for half of this for half the cost". And when we say cost, we meant cost. And we'd ask you to pay the rest of it. And think it over, you know whether this is really what you want done. So we would sort of leave it with the patient, the patient's relatives. And more then once the family would come and say well we got six kids at home, and there is no way we can handle this. So you would say, "that's fine" and would you encourage them to be comfortable with letting the child die. Those where times, you know, when you felt very much for the patients and their relatives, you know, and you realise the social situation. So those where some of the times.

The other thing was we didn't do any abortions in the hospital there. But we were perfectly willing to sterilise anybody who really needed it. There was like a Canadian fellow who came over visiting. He said: "in Canada I'm dead against family planning, you know, and that type of thing, so but after I've been in India for a while, I'm not so sure that it isn't the right thing for the Indians". **Oh its for the Indians, not for the Canadians.** Not for the Canadians, but you see he'd seen the situation of a dense population growing rapidly, so he was all for it. So any woman for instance, who delivered her third kid, we would really go to work on that woman, trying to get her sterilised. For the most part we didn't sterilise the male, because if we would really wanted to do the population thing, we would sterilise the female.

Now the Indians are always made out like there were really ethical and a really conservative sort of people, that they didn't practice a lot of marital, what would you say, martial infidelity, that type of thing. But treating patients, you really found out a lot about how India really functioned. So you really wanted to sterilise a woman, that would take care of some sort of subnuerance (?). Now the problem

was that usually grandmother was along. So when you took down the mathematics of the thing: you said: here is you and your wife, now you have three children, there's five of you, 'yea, we're 5', so you went from 2 to 5. Right. Now as your children grow older then they are all very much into family planning, so here you have 3 children and 2 are boys and one a girl, lets say. The girl goes off with the family, with the husbands family, but you have 2 boys and they get married, but they believe in family planning. So they only have 2 kids a piece, so that's 4 kids, right? Right. And 2 fellows here in your home, so you that's 6 right, and you 2 so it's become 8. So you went from 2 to 8. Now are your fields produce 4 times?" "No, Saab, no, they're not, they're hardly producing what they made before." See, so then you say, "Ok, so what does that result in? that results in famine, right? "yea" And famine kills the oldest and the youngest, right? So we check off his wife, 2 grandkids, so now you still have 5, don't you?" You went from 2 to 5. So then they get very serious about that stage, so then you'd say, "really, you really should think the wife should be sterilised, you delivered your third.

Then grandmother comes around. Grandmother had probably delivered 10 kids and 2 survived to adulthood. And she would shake her head, "and they wouldn't let me sterilised". So the inability to guarantee that the kids would survive till adulthood, immediately put the squeeze on. And these were the findings, this was just the practical way we did it in Central India. Same findings the education and the economic improvement, being able to guarantee the survival of the children to adulthood where the big factors in family planning become successful around the place. So we would give everything from medications, birth control pills, that wasn't very successful, putting in an IUD's and so on.

We only cleaned up the abortions that were already done in the villages. Women would be coming in bleeding and all the rest of it, and we give them advice at that time. **SO was there lots of 'wild' abortions going on?** Lot of private abortions which would wreck the women and infect them and so on, it was a real shambles. And the statistics suggest that in most of the 3rd world countries the 90+% abortions were done by midwives and other people in the community. With a tremendous amounts of law suits of mother, they were wrecking the reproductive system.

So you're saying that the Anabaptists or Mennontie teaching that you have gotten have been somewhat adapted in Indian setting, but they were still there.

We had no argument with prevention of pregnancy, that was a very practical sort of thing and theologically we could go ahead with it. If you prevent implantation's, that's just like multiple implantation that don't survive anyhow, that are shed. Its no different than that. So prevent implantation's, once, as far as I was concerned I drew the line at preventing implantations. From there on, you know, once it was implanted and so on, we respected that as an individual in the process.

So is most of your medical practise is that experience in India?

12 years is in India, all rest is back here.

So, you think of any practical examples over here, in the West, in the US, where you might have found your ethical teaching being interfering with medical

practise? Or you ethical formation like what you studied or Ilearned or acquired in church?

Well, I switched over to Anastasia, so I was no loner in primary care, and a, so for instance at the University of Kansas when abortions first started out, they were very carefully done for real indications: in other words, real indications, I can still remember that they had to get opinion of several physicians before they would be scheduled. So some early abortions were done very carefully. And can I remember a young black woman coming in for an abortion who had had 5 children in 6 years, just like that. And I can still remember talking to that woman before I gave the anaesthetic for the DNC, and she was just like a bomb ready to explode. So she came in for psychological reasons because she just couldn't take anymore of this. So 5 kids in 6 years, and you know I thought to myself, that certainly is a psychological indication for an abortion. Now why the could go ahead an use some form of contraception, I could never figure out, so contraception would certainly be indicated there. But then you know, we began to so people who came in with less indications, the indications became looser and looser until finally it became almost a matter of abortion on demand. That was not a pleasant situation. Now, we allowed anybody who refused to take part in that to drop out. So if we had for instance a resident who was dead against abortions, or a nurse, we'd find somebody you know, who could do it with a clear conscience. SO anybody who really objected to it, we would allow them not to. I was in cardio-thorasic Anaesthesia anyhow, so I didn't have too much to do with it.

But still, its a question that you know, you talked earlier about peace and non-violence and not going to military, and then you're face with the dilemma of having to be there in India with the abortions, and you have to there here in the US with the abortions, and there is quite a bit of dilemma that had to be reconciled?

For instance, in India there was a women who came in, she was a widow. Now in India widows are sometimes taken care of by a relative. They are supposed to be protected by this devan, who is supposed to protect this widow and take her interest into consideration and make sure you know she is protected, clothed, and housed and so on, you know, with a decent sort of ethical life. Well, her relative, her devan of course used her for sexual purposes, got her pregnant. Now here was a woman who came in a begged for an abortion. She could never say that this guy has been using me, because she didn't count for anything anyhow, she was a widow, she was a woman, her word meant nothing. Now when she would deliver the child, you see, than they would say she is not only that but she is a loose woman. She really had very little choice in refusing this devan, because he could say she's this, that, the other thing, and they would throw her out. So if there was ever a social indication for an abortion, this woman had it. It was incompatible with survival, with her social survival and possibly even her physical survival. That was a tough one but we said would still not do it. We said when you deliver the child we're glad to sterilise you, if that's the situation. And we would be glad to tie your tubes, and whatever happens after that you know, I mean got to life in that family relationship. We never saw her again, so who knows what happened, she may have well gone out and have

somebody in the village doing that. And that's what we saw all the time, badly bodged abortions coming in.

So they went to the village like doctor or medical men or whatever and had an abortion done and then came in with all the problems you had to fix after that?

Yes, complications.

Wow, that's heavy stuff.

Yes. So those where things. Now you see eventually abortions became legal in India, and the statistics suggest that with all the family planning anybody does and all the sterilisations, and all and the Indian government for instance, would put out their sterilising teams. They would have a team with a van come down and do vasectomies on everybody they could get a hold of. So they had various rewards for it, transistor radio or something else if they come and got their vasa taken care of. So they would pick up anything from old fellows who weren't able to perform anymore to young bucks, you know, and so on. A family brought in their brother, a young fellow who had sort of a birth anoxia, or something like that, so he was mentally he was never quite there. Physically he was a great specimen, you see. Well, they had grabbed this poor fellow and they sterilised him. So, here came the brothers, dragged this fellow in and said: "do you know what the government did, they forcefully sterilised this brother of ours, we want that to be reversed." I said, "the government sterilised him, the government can reverse it." By you see, by sterilising these thousands of males, they would have sterilised 30-40 thousand, their object was to sterilise about 30 thousand with each of these teams per year. That is a lot of people.

Are they still doing that?

No, I don't think they doing it that way anymore, but there are lots of sterilisations that do occur, and should continue to occur.

So let me ask you the next questions, if you think of developing a framework of Mennonite medical ethics, from a physiological basis of what you just talked about, what are the things you would include. What would be terrifically important to put in, if say MMA wants to develop a Mennonite Medical Ethics what is the stuff you want to put in there.

Probably the important things would have to do with respect for life, this would be respect for life prenatally and postnatally. So this would also be important in terms of how people survive, what for instance their physical situations would be in terms of food, clothing, shelter. So respect for life comes through in that aspect.

Then in terms of richness of life: integrity, infidelity within marriage would be a thing that would certainly needed to be encouraged, so that from family planning aspects from the thing. From the aspect of our responsibilities in society: the simple life allows for working in situations that are less remunerationally desirable, in other words, you could work for lower salary and do what you really wanted to and making it possible in functioning for those who care for those who are more needy.

In terms of response to government : government activity has to be evaluated in terms of effect both locally, nationally, and internationally, so that taking part in military activity or encouraging military activity would not be part of what we want to do as a MMA. So to encourage members of ours who be involved in the armed forces, to present to them in love that there is an alternative. Speaking to politics in the military, an attempt to keep from supporting military financially would I think be

important. Speaking out on types of armament that we prepared, the whole nuclear weapons issue which basically assumes that it is perfectly alright to wipe out a country when threatened by that country. So, first strike would be totally out but by the same token, preparing and accepting the philosophy that for some particular political reason one would be justified in annihilating 100 million people is a totally unacceptable this, and therefore the preparation for mass destruction is ethically unacceptable, that is in fact criminal. And since it permeates us in terms of how we expect to be defended by our nuclear weapons this is a grossly immoral thing by any standard. And particularly by the teachings of Jesus. So to divest ourselves of that deep psychologically implanted idea that we are actually being protected by our weapons systems would be important.

So society has to be challenged, challenged in love and you take the consequences of that. Which you know you do actually, if you discuss the nuclear issue in the 1980. IN the course of a surgery all sorts of discussions went on and they would sort of pick a thing and say "Duerksen, what about this", and so I would launch into a discussion of what was actually happening with nuclear weapons systems. And I think probably I got transferred out of cardio thoracic anaesthesia because the surgeon didn't like, and my boss didn't like it. My boss was a republican of the first order, and I think probably this being taken out of my subspecialty probably had to do with that.

When you think about a particular Mennonite medical ethics, or Anabaptist Medical ethics, do you think there is such a thing? or should there be such a thing if its not yet?

I think actually we talk about an Anabaptist theology which is not Anabaptist theology per se, but the Anabaptists took the Christian theology and said this is serious business and applied to all aspects of life. And because they were distinctive and broke with the larger church, we consider that AB theology, this is solid Christian theology. And where the NT is studied seriously people and adhered to, they will come to the same conclusions as our Anabaptist forefathers. So there is nothing distinctive Anabaptism as such, but this is taking the teachings of Jesus seriously.

And applied to medical ethics, how would that look like?

I think it would come into the highest form of medical ethics as respect for the individual, doing no harm, doing good, respecting that individual's wishes, that individual's personality, passing on what seems of importance, in other words raising the issue of after life, end of life, and so on but in a sensitive fashion, and respecting that. And where things are really being done in an unethical sort of way or in a way which is not compatible with ones understanding of Christian ethics, there one would have to oppose it. SO that's sort of in a nutshell.

So now, lets end of one last question: the president of Bethel College is calling you because you have lots of experience in medicine and all kinds of things, and they want to start a medical ethics curriculum for their senior students who go off to medical school, and want to prepare them thoroughly and well to enter medical school. And they are looking particularly at issues of medical ethics the

kinds need to be prepared with, or get a head start on dealing with when they get there. What kind of classes, course, would you put in there?

Well, the whole medical ethics field has been very well developed. I was in the medical ethics committee at ST Luke's hospital in Kansas City, delivery of care, treatment, the care of individual, the end of life issues, DNR types of things, when you withdrawal of life support, you see, and so on. And those have been very well developed. So that I think that would be the basis of any course. And then from that point on I'm not sure that there is that much more that could be added in terms of an Anabaptist theology. All these concepts have been drawn up in the secular field, so the only other thing would be a religious support, or spiritual support for patient and relatives. So that could be the distinctive aspect of Christian ethics as opposed to ethics. But the ethics have been very nicely done, and a tremendous amount of thought has gone into it. So that would be the basis and whatever you could add from that point on.

So you would say that in the care of the patient you would put in the religious aspect, or various religious aspects, and among those would be a Mennonite perspective, and that would fall into the care of the patient in the ethical question?

Yes, and the ethics have been designed that they can apply to any religious groups. I can still remember an episode during surgery, you know, when I was being mocked. There was a Christian fellow and a Hindu fellow who were just making fun, so what do you have to offer, etc. etc. etc. So I was defending and saying that Jesus Christ has something to say as to how we live and provides salvation, etc. etc. They were just making fun of that. All of a sudden the Moslem scrub nurse, she spoke up and said "Jesus Christ is one of our prophets." By everything quieted down, this Mennonite who was attacked by a Protestant and a Hindu was suddenly rescued by a Moslem scrub nurse, who said Jesus Christ is one of the prophets. You know, she had something else to say, but just a sentence or two and the whole place shut right down. They didn't dare attack her, they didn't expect it from her side. So a Mennonite was defended by a Moslem. So by the same token if we had a Moslem you see then we would get back to the things we have in common, and you know who can really get you through this last bit of life. Just like I did occasionally with the Hindus.

Have you ever thought of writing your life story up in a narrative or something?

Oh they suggested that, and probably there would be some interesting things there.

Thank you very much.

1 Dr. Lawrence Eby
 2 General surgery and emergency medicine.
 3 > general surgeon, several terms in India, South America and Africa; additional
 4 training in OB-Gynaecology
 5 > worked with Amish community for many years, is now administrator of a nursing
 6 home facility in OR.
 7 > social justice, access to health care, environmental concerns;
 8

9 **1. When you think of your up-bringing, I assume you were brought up**
 10 **Mennonite-Amish-Anabaptist, that kind of environment (Mennonite), are there**
 11 **any particular Mennonite teachings that were instrumental in your choice of**
 12 **career? Or people, situations?**

13 Well I, its hard to separate the two [Anabaptist theology and ethics], I would
 14 think that it was my home more than the church or theology that did it. It came out
 15 sort of backwards, in that, in my home I was one of six boys and one girl. And the
 16 highest calling as far as my parents were concerned, especially my father, was some
 17 kind of ministry. He somehow hoped that at least one of his sons, and as many as
 18 possible would become ministers. And he was somewhat disappointed that two of
 19 them did but no in the Mennonite church, it was what was then called, Mennonite
 20 Brethren in Christ, sort of Mennonite but with a Wesleyan bend and it changed now
 21 to the Missionary church So in a sense the qualified but he always kind of wished
 22 he'd have a son in a Mennonite church. The one that was really picked for was an
 23 older one who managed to get himself killed in a logging accident as age 30. But
 24 anyway, it was sort of a sense that this what was really the highest calling. In a sense
 25 that rubbed off on me, and I was the youngest and I somewhat wanted to proof and
 26 please.

27 And so there was this idea. And for instance I went to a missionary meeting, it
 28 wasn't in a Mennonite church, and my father said when we came home, 'he's wished
 29 he could have been a missionary', so that was sort of like a dream kind of thing.
 30 There was always this thing. SO I kind of thought as young lad I would become a
 31 missionary, but it really wasn't from a sense of calling from above, but rather from
 32 family expectations and family aspirations. So that was really it, it wasn't defined as
 33 medical, that would've been my father's wildest dream, something he would have
 34 never imagined.

35 **But he would have said anything against it, would he?**

36 The only thing against it when he knew I was serious about it (becoming a
 37 physician), I think he expressed once a concern about evolution being taught. And
 38 that was the only thing, other than that he was extremely supportive and went out of
 39 his way to see that I could afford to go medical school, even though he couldn't
 40 personally help me. He had no finances himself. I was going to drop out of college,
 41 but he talked to my sister and asked her whether she could loan me money so I could
 42 go to college. It was really interesting I was even planning on going into Voluntary
 43 Service for a couple of years, which would have been quite approved, but when told
 44 him I really liked to go back to college to get into pre-med, that was when I made my
 45 decision at that point, he was very supportive.

46 It was the service, serving the church, and especially the Mennonite church.
 47 Because he grew up old order Mennonite, in fact his roots are right up the road here

but he moved to Michigan when he was a young lad. But we were still in a very conservative environment and he grew up conservative. He changed to the Mennonite church because of various reasons, probably more theological, or at least spiritual than just so he could drive a car. But he still was a very conservative persona. That was about as far as you should go as a Christian in terms of modernisation. Everything else beyond that was cutting your hair and that sort of thing that he could not agree on.

SO you that is theological conservatism, you would describe as external signs, or did it have attitude stuff as well?

There was quite a bit of attitude there too, he was financially a poor manager, but he was unscrupulous honest that he couldn't hardly help but fail financially.

SO theological teachings you would not call instrumental in your choice of career?

Our theological teachings were a heavy dose of bible quotations from the pulpit. It was there, there is no doubt about it in terms of services, we all took it as part of our live to do things for other people. Youth Missionary gardens to raise funds for missionaries, my Dad saying he would give to the missions bis es web tut' (until it hurt) That's how much he would give. He was so sure about Goshen College, you know, he wasn't so sure about giving to Missions until it hurts.

So in your spiritual development, becoming and owning your faith, where you every able to say this is 'theology' this is emotions, this is phychology. Has theology and ethics every been separated? In other words, is there are separate place in Mennonite thoelogy the way you grew up?

We didn't think about it [ethics], I would not have thought about it. Ethics what you sort of knew you should do and did [it]. I don't know. In college I took a semester of philosophy and a semester of ethics, but I still when I talk about ethics I have to stop and think. So, at what point would I have pondered such a thing. I'm not sure, it would not have been a consciencous thought, I don't think. When I started to think about what the things that I had been taught about in growing up, when I started thinking about them more objectively would have been in college. Because up until college so much of my church and my home life in relation to the church had to do with being ok, with being accepted by God primarily. And in my up-bringing that was sort of burden, kind of a heavy burden. My parents came out of that very conservative atmosphere where behaviour was extremely stressed, but belief was only having the right behaviour. I mean there was not a lot of theology there. And then got into the Mennonite church at the height of the movement into this Mennonite fundamentalism which stressed was dress but also stress very much an experience of salvation, a being saved type of thing. We didn't talk about that a lot, except it was something that I knew my parents were very concerned about us. When I was about 13, the way my brother put it to me was 'are you thinking about joining the church?' Which to join church you would have somehow have to have this experience.

Through highschool I wrestled with this 'am I saved, am I not saved'? And it was interesting really when I went to Goshen college, it just happened, have you heard of the Brunk Revivals? George Brunk was a evangelist in the Mennonite

Church who ran around and had tent meetings all over the Mennonite constituency in North America, including over here. And he had a very strong emphasis on accepting, being saved, also sort of a pietistic approach to almost a second grace. And I got to college a few days early and we went to the Brunk revival and I was convicted, and then went forward and I had an experience that was very meaningful because it kind of released me from the guilt that I had felt up to that point. Even though I had gone to similar experiences before, this one 'did it'. I think, it was highly emotional, it was really basically an emotional thing. This is where my reflecting has come in since, what happened that was different. Up until that then I was conditioned by my background that I had to have this sort of thing in order to unload it. And so I look back at it as a meaningful experience which I had to have because of my background but not a normative experience for anybody.

That thing we had a heavy load with was hell. It was so portrait in such graphic ways, that as a child when I got to be an adolescent I couldn't enjoy a bonfire because of those pictures in my head. It was pretty serious. Anyway, the reason I'm saying this, that experience, and then going to Goshen College and starting to take some courses. I had some excellent teachers, I got a bible major in addition to my science major, and I had some really good teachers, and I started to reflect on what is important in terms of Christianity. But I've been doing that ever since and so I've changed a lot since I left Goshen College.

I would say in terms of ethics, it sort of evolved with that, I can't really point at any....The one came out of the other, the ethics flowed out of the biblical teachings, theology or whatever you want to call it.

When you think about then over you work as a physician, it Surgery (and emergency medicine), have you encountered times or case or situations when you found your practise as physician that you had to do, and your theology and ethics in collision course?

Well there were certain times when what I would have been taught, what might have even been the expectation of my Christian church community and what I ended up doing, and found I had to do was definitely collision. I did two, what might be called abortions. One was for medical reasons, and one was for sociological reasons. The one was a Amish woman who had extremely bad heart disease and I don't know if she would have been a candidate for a valve replace or not, I don't remember her diagnosis that well, but her physician, who also is a Mennonite doctor, asked me if I would do an abortion on her because he felt it was the only way to save her life. **And she agreed?** Yes, she agreed. And we did it, she survived the operation and lived a number of month. I was quite convinced that she would have died before the child would have been born.

The other one was a different case. We had a lot of people from a nursing home. There was a young woman/girl, probably 15, 16 years old, nobody knew who did it. The word was that nobody knew who did it. It happened in the nursing home. And she was quite pregnant, she was 3 -4 month probably. The family doctor who was a Presbyterian talked to me and said: "I would like for you to do it, the abortion." He said: "This should not have happened, the family are irate, the load of care for that baby would be just terrible, and we can avoid a lot of problems if we do this". I'm don't know if I really thought about it a lot, and I didn't invite anybody from

church with it . It was a decision between me and him and the family. The only regrets I have is that I didn't prepare our operating room staff for the fact that when the child came out, we did it trans-abdominal. We didn't have an obstetrician, so I was the functional obstetrician, and so didn't know the trics of later term abortions. Although this was probably first, beginning second trimester. And the other thing was we sterilised her at the same time, we tied her tubes, so for by any chance that this would never happened again. It was decided ahead of time with the family. The person herself was like a 6 month old, mentally, she infantile, she came to the operating room holding her doll. No even though regular people could do that, but this was an infant that was pregnant in terms of emotions. And so anyway, when this foetus came out still moving, that was kind of a shock for some of the people at the operating table and I had not prepared the for that, or even given them permission not to participate. I regret that. Myself I think we did the right thing. There is a case there.

Another very interesting situation we had. An Amish woman in her sixties I'd say came in and had what looked like an acute abdomen. We took X-rays, we didn't have, this is before CAT scans, you know, so all I had to go by was an abdominal flat plate. And you looked for free air on there, she had no free air , so I delayed surgery for a little while, until it became obvious this was an acute surgical abdomen. Here she had perforated her small intestine, as I recall, there was no constriction. So there was a delay in operation, partially because I was a little slow in making the judgement, which I usually wasn't. And she got a shot lung, and her oxidation went down, and the only way to save her life was to put her on the respirator. I had an internist, and internal medicine physician, who was quite bright, I really depended on him, and he managed my respirator. She didn't want it, she didn't want to go on it, the family was there, but she did not want it. SO we said "Alright, you're going to die if you don't have this, why don't we put you on it, and you get better, or not worse, and it looks like you're going to recover, and it think we put a time limit on it' Well I don't know, I think she was a on it a couple of days, relatively consciences, we didn't knock her our or anything, we only sedated for he comfort. So time went by and she did not want to continue this. So we said, "ok, we have two choices." It was going the wrong way, it was getting worse. And we said: "We can move you to a bigger hospital, maybe they can save your life, we don't know they have more sophisticated people there. They way we're going now you're getting worse. Or if you absolutely want it, the other choice is to take you off the respirator, but you're going to die, you're not going to live very long". I don't know how long it took until she begged to be taken off that respirator, she didn't want to go away, there was no point to continue, it was going worse, and she wanted to be off of this thing and to die in peace, and we did it. This woman was conscious, I went in, removed the tube, left her with the family and within a ½ hour she was dead.

So autonomy of the patient with all the information they can understand to make a choice was important for you?

Yea, oh yes, I never in my practice I wasn't faced with those cases, o never took anyone else off the respirator. Mostly I didn't have that kind of patient load. I didn't have the head injuries went elsewhere, so there were just a few cases like that. And the only other case I can think of quite like it was when I was in Puerto Rico

where the guy died in the ambulance cause it was a long trip. This was, the patient understood, the family understood, the family regretted the hole thing and then brought up a few things about if I had operated earlier, which Amish people do, a lot of people do, and I felt that way too. I felt badly that I hadn't gone in a few hours earlier, which might had mad a difference, but in medicine you live with those decisions. Well, if they hadn't been Amish it would have been a hole different thing.

So do I understand that right that you have worked in an Amish community mainly?

They were about 40% were Amish, for 17 years, that is were I did the bulk of my surgical work was with them. There are many different kinds of Amish. There are some extremely conservative ones that would not have no kind of insurance at all. I had some of those, mayb about 5% of them. Most of them were kind of regular Amish. Some of them, the more 'high Amish' is what Mennonite Aid was when I was a boy. Every year there'd be an assessment depending on how much money they needed would be what the assessment would be. And then other places they would pass the hat, or what we would call take an offering. Our hospital was in rural Ohio, Holmes county qualified for federal aid because of the per capita income of the people. And the reason the per capital income was low was because Amish was low cash flow. But our self pay was at our hospital was about 1/3, but our collection rate was over 90% for the hole hospital. Even though they had low cash flow, and they had no insurance, they paid their bills. So I had very few debts with the Amish. They had no insurance and not much money but they paid their bills. When I left practice I send out a notice to all those people that owed me money saying that I was leaving practise, And whatever they could pay now was fine, I was not going to send them anymore bills, as far as I was concerned if they could pay all right, otherwise the debt was cancelled. A few of them kept sending me money for a couple month, but most were cancelled. It wasn't that much 5000-10.000 dollars. Most of those actually weren't even Amish.

So are there particular traditional dilemmas which you encountered working mainly in an Amish community. Thing which are more theological issue why they don't have certain treatments?

The health insurance, I have no idea whether refusing treatments would be theological issues. I believe they're sociological. They're the community ethics, the primitive culture ethics. I also practice three in Puerto Rico and three years in Nigeria. Actually probably the closest parallel was with between Nigeria AND the Amish, in terms of folk medicine and in terms of what they would do for themselves and what they come to you with and what the expectations would be. I think there is a lot of parallel.

The Amish, most of them, prefer to try everything else first. Which is all right in a way, and I've come more in their direction than when I started. Because I believe more in homeopathic balanced approach then I did when I left medical school or even when I practised in the Amish community. But, they are soo gullible.. They are so innocent and have so little knowledge on which to base decisions about the choice of medical care. And then they also have ideas like in surgery, that if you have cancer, and you're operated on and you open the abdomen, that's like putting oxygen to the fire and it spreads it all over. I came up with the comparison with the fire.

Because that's the way how I could conceptualise what they were thinking about. I think in their mind they're comparing it to a fire, as long as you keep the cover over its smouldering but it's not going all over. And the reason they believe it, well, they'd never told me this, but I think indeed very often maybe they felt a little ill, but they're not that bad, and finally they came to the doctor, and finally they had the diagnosis and here the cancer was totally out of control. So you open them up and they died within a week because you happen to make the incision and open that abdomen. Now they may have had 2 weeks longer if they hadn't done that because of the throw?? of the surgery. But anyway, that would keep them from having surgery and they would delay and try other things first.

Early in my practice this older Amish woman came in and had fairly extensive carcinoma in her rectum, low rectum. And she came to see me, she knew she had that for a long time, she was bleeding and all kinds of things, I don't know, a year or two years, who knows how long. She was drinking some herbal tea and she said: "I know it was helping me, and I know if just could have been drinking enough tea it would have taken care of it, but I just couldn't drink that much tea." It was like she still had faith in it but finally she had to come to me because even though she was consuming a lot of tea it was getting worse. I think she was denying, I think it was a form of denial. What person wants to cut their rectum out and put a colostomy in. I don't know at what point she knew that what she would have to have. They're sophisticated enough to know that colostomies are out there and so forth. I think for them more than some other modern cultures that would be an abhorrent and unnatural thing to have the bowl removed.

And the other one was, there was a woman who was, she was Older Order Amish, I think, her sister was a Beachy Amish. And they lived right near us, we were friends from day one. I saw this woman in the hospital. She'd come in with a partial bowel obstruction, large intestine, her doctor was one of the Mennonite Docs. I'd actually have experienced earlier on, that sort of sharpened this. There was this older Amish man who had a partial bowel obstruction, also large intestine, and insisted on going home and Dan said, "let him go home, he'll get worse, and then he'll come back". And he did, but by the time he came back, it was really hard and he ended up dying post-operatively. And I was a culprit in that situation, because I was the fault guy, because he went home and he went along with it. So anyway, then this other, I remembered the case and thought I'm not going to let this sort of thing happen again.

Anyway, this woman, she felt better, unobstructed, but you could see the lesions on the X-ray plain as day. And I told her it was there, so this sister came to our house and she said 'would you talk to my sister again about this, because we would like to have her operation now.' I said, I'd be glad to. They talked to her and she came to my office, and I just laid it out. The complicating factor was this woman was some sort of therapist with lights she had some sort of lights in her house, and she treated people. And so she was the therapist, and it was a failure which she had trouble admitting. So anyway, I laid it out, saying 'right now I can't promise anything but I have a chance to cure you. But if you wait until this gets bad, I'll feel badly. I take care of you but you will have taken away much of my ability to help you if you wait.' She went home soon I got the message and she came in. There

was very cold wall contained cancer, I removed it, and some year later her sister told me how pleased her sister was that she'd had it done.

So there is a mentality that because of the lack of information they wait too long but then there is a mentality that they don't reflect on that waiting too long for treatment.

I don't think they have a concept of stages of cancer, you would have to teach them that. And that would be extremely difficult. I think some of them do. I don't know now, I've been gone for 10 years now, I wasn't in on the primary care. So I don't know for instance, how many would have a Mammography, I suspect some of them would, some of them getting quite sophisticated. But by and large they're not. We're starting to sterilise some, with permission, of course. They don't want those gigantic families, but they wanna keep of having sex, you know, how you do it. They would be opposed to birth control pills or condoms, but so really its kind of what you can get away with, without the Bishop knowing. Post partums are especially popular, because its part of the being in the hospital anyway, so you can do that and they only stay one more day. Especially when they're like to have their appendix taken out in addition, so they can say they had to stay longer.

Would you say there are characteristics of AB theology. When somebody looks from the outside at Mennonites, indiscriminately seeing The Mennonites or The Amish, would you say there are characteristics?

I base this on my Homestad experience cause that's where I have seen the most about the Amish. To some extent we're rather clunged together, although I think most people in the Community would have know that Amish and Mennonites are together, but they would've looked at them as being odd. I don't think they would have understood to any great extent at all why they looked the way they did. They connected very much in business but very little in spiritual, theological church affairs. The pastor of the Mennonite church was part of the ministerial with the Amish, and so there was connection. We had ecumenical meetings at Easter and so forth. For the most part they like to have them as part of the community, maybe during WW II no, but while we were there (it was all right). I think they like to have people pay there bills, for instance. At the hospital there was some tension knowing how to deal with the Amish. The hospital was very dependent on them for patient load and part of the reliable patient load. They came in and paid their bills for instance, but they wouldn't serve on the hospital board but they still wanted to have there say in a way but they would say it by boycotting not by coming out and voicing their opinions. And so that was kind of a thing where they had to try to understand them. We had an administrator, who actually grew up in the Danzings, south of Danzig, and escaped from the Russian army. His brother carried him across the boundaries into the Baltic. In fact he almost went into Dresden, but for some reason detoured, they would have been in Dresden during the fire. He talked German and he really connected with these people so he seduced two of them to sit on the board. He would pick them up, bring them to the board meetings, and they'd sit there, and they'd be ask questions and would give their input. It was an interesting arrangement. No idea if that's continued, I'd left, but there was a lot of effort on part of the hospital

to connect. But it was really a business connection. They did it with a great deal of grace and understanding.

Would you say in an association like this should think about developing Mennonite medical ethics What would you put in there?

I think so. We spend a lot of time on what should be access, what kind of md's nurses we should be, personal component all that sort of thing. We keep bringing that back. I voiced a concern at the business meeting, I believe its ethics, I think we need to start speaking to our constituency, that is our Mennonite, about ecology, the health of the planet. We have been totally silent on that. When I saw global health, they're not talking about that global health of the globe. I think the bigger threat to the globe than anything else is what we do in ?? and Mennonites are very complacent about that as a hole. And nobody is in a better position to talk about that than Mennonites. We do have some ecologists is our membership that are very vocal, but they are such a small minority. And its not a popular thing in their publications. We're operating a camp, and that raised our consciousness how to deal with it, but there were people that if we start talking to much about nature, about the spiritual and nature, oh boy. You know the two guys from Harrisonburg, the comics, Ted and Lee came to camp. So this one guy who had been involved with camp forever, gave some money, came to me later, saying, 'you know, some people didn't like that'. I didn't really push him, but he didn't want that sort of thing at the camp, it wasn't biblical, to him it made fun of scripture. And the thing is he is not that holy and righteous himself. He goes to that restaurant every morning, and flirts with the waitresses, the guy is 60 something. I'm mean he's not pinching them or anything like that, but he is denfinitely flirting. But this guy believes that we have to be very proper and scriptural about the camp. How did I get on that?

About the ecology and the responsibility of the planet?

SO anyway there are those people in the constituency that don't want us to be that involved. And we want to be good biblical Christians, Mennonites do, and that's allright, but I think the way you define that.

So you would say it is a stewardship issue.

But you have to go beyond stewardship. Stewardship is the idea of how you use the resources economically. I'd become rather radical in the last years, partially because I have this radical son, and partly because I've read books like Eco feminism, and Deep Ecology. The tree may have a personality or a spirit, really getting fairly active in native American theology, I think we need to listen and pay attend in how we treat mature. Whether or not the tree has a spirit, there is something about thinking twice before you cut it down and thinking whether or not you really need this tree. And that goes for nature in general, because I think this is only way that we can have the globe sustain us for an indefinite period of time. And we're already close to being over the brink. Some people would say its too late. And it bothers me that Mennonites are just going right along with destruction. Fear of worshipping nature. There is a fair amount of that thinking (destruction of earth that Jesus can come back), probably a minority that really approach it that way, but its significant. And those are the people who sometimes we hear from.

If you would be asked by president of Goshen asks you to do some brainstorming and put together a medical ethics curriculum for the pre-med and nursing students, with what classes/topics would you challenge the students?

I think in order to make decisions, they do have some classes like that, but there needs to be some understanding what the sources are of our biblical teachings. And a ability to reflect on them in a broader sense than just the inspired word of God coming to us from above. But rather that we have to understand biblical teachings on the basis of where they came from and what formed them and their relevance for the present, they have to be brought into the context in order for us to understand what they meant. That to me is crucial for in terms of making ethical decisions. I think they have to ideally they would have an orientation towards, when they bring their biblical beliefs in that it goes beyond what they've learned in PA or OR.

There needs to be some talking about what the meaning of life and death out of the AB/Mennonite understanding. I think we need to reflect on who we are as the citizens of the globe, and I say that in the context who we are in relation to other people, other cultures and to the rest of creation. Because I think that would be very crucial in terms of physical and mental health in the future.

There should be case histories of the sort that I had to face in making decisions regarding life and death sometimes. Its hard decisions, with many you couldn't even go to church with because it would be understood.

Well, thank you very much.

1 Dr. Merlin Friesen,
 2 Indiana,
 3 > practice in low income area, offering of low cost visits for uninsured patients;
 4 supplements personal income on ER shifts;
 5 > focus: justice of access to health care; disproportionate income of MD from people
 6 who cannot afford health insurance; what to be done with affluence; peace position to
 7 apply in health care; individual autonomy for patient decision, maximising resources
 8 in advocacy for underprivileged,

9 **1. How did you decide to become a physician?**

10 I went into it for status and acknowledgement that went with it, and that
 11 motive for serving. So, There where lots of self-serving motives. But I wasn't
 12 practising Mennonite I guess at that point. I had some Mennonite background, but,
 13 spend time with some Mennonites in a community centre in Henderson, NE, and it
 14 was a dream of going back to Henderson as a small town doctor, not necessarily
 15 being allied to the Mennonite perspective but just the small town element that drew
 16 me back to Henderson. And then my own distant Mennonite roots just began to just
 17 be reawakened. The root that caused me to leave Henderson in a situation of burn out
 18 also raised some troubling questions, I guess, for me at that point living in a you
 19 know, supposedly Anabaptist community. I watched the community make decisions
 20 in terms of health care resources that I didn't fell was at all authentic from an AB
 21 perspective. Very much "we are going to have what we want, at any cost, whatever
 22 we can afford, we are wealthy". And so it was an awakening for me, the questions of
 23 what does it mean as an AB to relate to the whole world, to live responsibly, to have
 24 limits, sort of issues that the Amish raise.

25
 26 **So even though you say your motive where ulterior motives to go into medicine,**
 27 **have you been, have there been any characteristic teaching of Mennonites or**
 28 **Anabaptist theology that would have been instrumental to choose that kind of**
 29 **profession? Or was it more like a counter-reaction to the way you grew up?**

30 I think the holding a service profession in high regard, has some Mennonite
 31 roots, but it wasn't necessarily unique to that. The way that we practise medicine I
 32 think that become much more important to me as I've gone farther into my life and
 33 my career. Integrating that with an Anabaptist perspective but it wasn't Anabaptist
 34 issues weren't issues; for me I guess I wasn't really engaged very deeply in
 35 Anabaptist questions when I made the decision to be a physician.

36 I went to Wheaton College, evangelical environment, Medical school in
 37 Houston at Baylor for Med school. There were important roots of Anabaptist
 38 connections, Mennonites threads in my growing up but that ended up being the
 39 chords that kind a drew me back to it.

40 **So then coming back to Henderson was a good experience until the burn out**
 41 **time came?**

42 It was a good experience and yet I don't view it in retrospect as very authentically
 43 Anabaptist. Henderson was a very much a community of privilege, a community of
 44 wealth and known in the surrounding areas were a wealthy community. Not that
 45 Anabaptist issues are not near and dear in many ways to people there, but some of the
 46 economics of medicine and how we as Mennonites relate economically in the world
 47 and what kind of expectations we have for life style and all that. That's kind of

troubling to me that those issues don't seem to be very visible in the Henderson experience. They weren't lived out except by a somewhat visible minority and those ended up being models I guess, for me that inspired me to scratch a little deeper into Anabaptist history and thought and to read.

When we made the decision to leave Henderson a prime opportunity opened up for us to go on an MCC assignment on an Indian reservation. And that used to be the catalyst to be able to read things that MCC made available to us, to read a little bit of John Howard Yoder and many well know modern writings from Anabaptists, and to really start to engage with what kind of difference in terms of community, in terms of lifestyle, in terms of service mentality that being Mennonite ought to mean. So I guess it was an ongoing progression from there. Now how do I apply this?

So when you think about your up-bringing, spiritual development, faith-owning process, as I come to call it, is there a place where you put ethics in there with theology and with faith, or is ethics something that hasn't ever been talked about in a separate way? Can you separate out where your ethics has come into being?

College experience was good in terms of exploring a little bit some of the biomedical type ethical questions. My background in evangelical churches was really weak in terms of any kind of ethical thinking. But the college experience sort of awakened what some of those questions would be. Wheaton had a fairly good medical ethics course that was required for pre-Meds. It was called health professions seminar in those days. It dealt with not only issues of abortion and euthanasia, which became then the really hot topic subsequently, but already at that point was beginning to explore what it would mean for every hospital to want to have all this technology to have available for them, the competitive environment in medicine, HMO, and what that might mean for medicine.

But I guess the things that burn in my soul now really came about from engaging with fellow Mennonites in Henderson, then reading some over the last 10 years. And that's really interesting, I'm surprised to have as much trouble in pinning that down as I do, but the economics of faith, the ethics of how we live and serve in the world, how we consume resources. That thinking probably goes much more to just personal reading, MCC really catalyses a lot during their orientation process.

So Mennonite theology when you grew up wasn't necessarily having a focus on ethics, or has it not been talked about?

My exposure to Mennonite AB thinking in the 60 and 70 as I grew up, it was spotty, because I didn't grow up in a Mennonite community or Mennonite Churches. But I had summers consistently in Mennonite community, that was my rootedness. I don't recall a lot of ethical thinking other than pacifist. And, you know, on a very fundamental level the issue of concern for the well being of others instead of our own. Service is maybe heart and soul of where I'm at now, the idea of feeling like a fundamental conflict internally to me to become in any way wealthy taking care of people who are poor. That's really to me a gut wrenching issue. And maybe it goes back to all those care packages and health kits and what does it mean for us to be wealthy and relate to brothers and sisters who are not.

Do you have a conflict then with this organisation and its wealth?

I haven't really explored that issue in much depth, I guess I am troubled by the amount of wealth accumulation that we Mennonite professionals have become comfortable with. How do you live authentically in the world with that dynamic.

2. Besides pacifism that you choose as characteristics for Mennonite theology? Are there any other issues you would consider typically Mennonite?

Well, pacifism, relating force fully in justice concerns. I'm quite involved currently with my cousin Karen Pauls who has just come out of Iraq. That is really highlighting with some of the issues that we as Mennonites have to deal with in terms of rank, social injustice, and our acquiescence, our quietness about the issue. So justice is more and more of a concern. Key concern to me, it really turns my crank in the area of the dilemma of the uninsured in the US. That really maybe what has driven me to do what I do now, is that I think this is a terrible injustice what we're dealing with in the US. Another issue of course, the issue of community, and how faith has such a strong community dynamic. I probably was really kind of ignorant about that until I started dialogue with some MCC co workers, and read about that. I find that more and more a begging questions. Its something that really feeds my interest to work among the Amish people, is to engage in the process of community and to be maybe welcomed into it in little ways, just enough to experience it a little bit. An Amish crew roofed our house this winter, and a dozen of them, 6 buggies out in our front yard in a kind of a residential country neighbourhood. And to sit around a table with these dozen men and just engage and observe how they relate to people that they rubbed shoulders with for years and year and watch what that meant. I find very interesting, to translate that into our own Mennonite fellowship and begin to ask, how does decision making have a community dimension? How do my choices about even economic lifestyle relate to the community? Are we just a bunch of individuals or are we really authentically living this part of our heritage?

Are you still working on the Indian Reservation?

No, that was 2 years, ending at the end of 1995. 4 ½ years we've been in southern Indiana in a rural community where a Mennonite group of physicians started a practice 25 years ago. I joined that group but found my heart moving in the uninsured direction, so 1 ½ ago we made the move to start a medical clinic limited to people who don't have insurance to try to experiment with a low cost care delivery model that was affordable for uninsured people. And to see if that would create a viable access, and it is. But I'm largely do that on my own, with an interested board with a co-worker whose heart and soul is in the same idea, even though she is not Mennonite, and my wife's part time involvement. My wife is a book keeper, helps out a little bit with reception stuff, very limited time involvement, but and also enjoys being involved with Amish home deliveries that we do. But this is a practice that's 90% non Amish. We have a population of maybe 1000 Amish nearby.

SO you moved out of that practise you were in before and they're basically not interested in helping you out an seeing this thing going?

No its a little different from the vision that brought the group to the town. I guess it isn't a real divisive thing, we still have some pretty significant co-operative agreements, but they're practice is an all-comers practise, including making some really forward arrangements to try to help take care of some uninsured people,

discounted care and all. But I guess my own vision and sense of calling was that the needs of the uninsured were begging for something maybe a little more fundamentally different from the high-cost, high-tech care model as it is.

Your medical practise setting is probably unique, and maybe the question is a little bit beside the target, but when you think of your medical practise, and your faith and your theological conviction and your ethical conviction, have you every encountered a collision between what you have to practice and what you think needs to be done>

Certainly, you know, I'm trying to think of pet examples. I guess there are some real foundational issues. The fundamental value of a medicine prolonging life, of saving lives even though we have a lot less effect on that than we like to maybe think we do. But that's our foundational value of a profession, I find very lacking as an Anabaptist, you know, this is not what life is about, its prolonging life. Life is about living authentically and living with open hands toward others, and relating creatively in our relationship to God. And having lives that are whole and that are not fragmented or torn apart, or running in a hundred different directions. And my medical profession says that the value of a medical life is being extremely busy, in status seeking, and in making lots of money. All of which just flies in the faith of my Anabaptist convictions.

Now in terms of ethical dilemmas of medicine, well yea, those do come up from time to time. I'm not asked to do abortions. Although I can name a case were I had an angry Mom badgering me why I had not offered her daughter abortion counselling for a pregnancy. But I don't hold that, its not valid for me at that point. But issues come up much more frequently. The prosecutor's wife three days ago, was coercing her 77 year old father to come into the hospital when he had told me in no uncertain terms that he had no wish to be hospitalised even though I advised him he should. And supporting his autonomy there, even though I had a very angry lawyer's wife on my back, that's a medical ethical issue to me.

So the autonomy question, the question of sustainable living but not excessive living those are the things that are dear to your heart in your medical practise as well as a Mennonite Christian?

I'm not sure the autonomy thing is a fundamental, I mean it is an important issue if it comes up, but as a recurring issues its not. I guess the issues of compassionate living, and seeking out the poor or the marginalised and focussing on it, that seems to me to be an Anabaptist, or its a Christian's niche, which AB have historically recognised. So that maybe is really more fundamental to me and its on a daily basis, is relating to people who are marginalised.

Are there issues of a more rural and low income practise, are the ethical issues that you would face, maybe issues of confidentiality, spousal abuse, and maybe domestic violence, would that be falling into your work as well?

They could, I have to say I have not been tuned into that dynamic. I don't think I have learned to know the Amish community well enough to be able to see the abuse questions come in, but I think that's a hot topic and its a topic that gets a little close to us who have grown up in rather closed AB communities. Paternalism. Supporting people's autonomy in end of life issues, I think that's really important to

me, that's not an infrequent issue. And its one that I find really stretching in dealing with the Amish where life prolongation is such a low priority. **Why is there such a low priority on that?**

I guess I'd like to believe there is some authenticity, people who work around the Amish often times get a lot jaded about the hole thing and reduce it to just financial terms or paternalistic, patriarchal kind of issues. I'm convinced that they're some Amish who truly see life value differently than the surrounding culture. And some of this goes back to my experience of Native Americans who in some ways embodied AB values better than many AB. The fulfilment of ones purpose in life can be quite full at an early age. If you've raised a family, if you've lived a life of several decades, then life is not be clung to at that point. And the AB thread of community, living as a member of a community where you don't take excessively for the community but share, I know that is an issue for some of the Amish as well, for they consider health care to be a high cost resource to be expended very carefully because it is a community resource. **Is it true that the Amish don't have health insurance?**

They deliberately refuse health insurance. I'm not clear on that, my assumption, and I think I'm somewhat safe in this, is that they shun every program that is outside of the church. The concept of mutual aid is alive and well but it is within the community, it is not outside with the non-Amish. So, reliance on God and reliance of the help of each other is pretty much were health is thought.

So when you think of a framework for the practise of Mennonite Medical Ethics, what would you from your perspective in your work that you're doing right now, what would you definitely put in?

Well I know of what drives that discussion goes back to the pet issues of abortion, euthanasia and genetic engineering, etc. And I'm afraid that an organisation like this could get its attention grabbed quickly by those issues. I'm a member of the CMDS, and I'm very dissatisfied that's there definition, that's all they're talking about. I think that we as AB have a set of much harder questions to wrestle with maybe in some ways, because they hit near and dear to each one of our lives. That is issues of just living, life style, and seeking out elements of injustice in a society, especially things that have to do with health access, we should be putting those in front and centre of our attention, in my estimation. That people who can't access health care should be the top concern of AB who are in health care. Another troubling issue is our excessive reliance of personal wealth accumulation and what does that mean in terms of authentic living as a Christian. Cause I think the wealth accumulation is a very big thing. I'm not sure if falls under the rubric ethics, I hate to side-track what you're exploring, but that is to me an ethical issues. It involves life style decision making, it involves directing our medical practices. Those are intense theological issues too, where do we put our faith? Do we put our faith and security into our earning ability? Or do we put it into a benevolent God who can take care of us in any situation? But whether that's ethical is a matter of definition.

Can you actually do ethics without theology?

Ethics is the other side of the coin of theology. Where is your foundation point were do you anchor enter into. Those are troubling questions. I fly an air plane, its a disease I have for a long time, I find it troubling cause it projects an image of affluence that I'm trying to shed in other ways in my life. In fact its not really that

more affluent that plunking that money down the bank account for your retirement. But the image of it, so as a result I brought this in an initial way to our fellowship. “you know, can we dialogue about these things. Its little late for me, I’ve already bought the plane but I could still sell it. and maybe if there was interest in this kind of dialogue and mutuality, and saying, you know, I’m not the autonomous physician individual, I’m the member of a living community, supposedly.” So what does this mean, what does this mean to all of us as physicians, do we hold our own personal independence in high regard, or do we live as members of the community. That community element is a recurring theme that I am more and more in touch with, and Community can also have a dimension of the MMA, can be a community of people who challenge each other.

If you think of being called by Goshen college to come on as adjunct faculty to teach medical ethics to pre med students, and you really want to get them going, and get them prepared to face medical school, what would you teach them?

That’s a fascinating question. Right, well I think the issues, the traditional biomedical ethical issues, are real issues, but I wouldn’t give them exclusive press. I think that the to me it would be very important to explore what are the core values of Anabaptist Christianity. Relationship with God, peace and justice as fundamental expressions of that relationship, and how it translates into horizontal relationships. Community as this key element in faith, and then to bring in where the rubs are in medicine. Cause I mean there is a fertile ground there, people are actively acculturated in medical training to do exactly the opposite of all those values. And we spend years and year of training in early years of practice and all of a sudden we find ourselves in MMA kind of groups to undue all the damage that has been done you know.

What will it mean to live in community, to have your lifestyle responsible to a community of faith? And what will It mean to explore issues of peace making and justice making as a medical person? What kinds of injustice issues will you need to address, what kinds of service things will flow out of that? Will you tailor your practice to a good paying clientele that all have insurance cards or will you tailor it to group that don’t pay you as well? How will your life be hole instead of fragmented? And will more be the model of your life or hole be the model of your life? Those are probably the key issues that I see medical training just completely erodes. And I guess, my thesis would be that even us as Mennonite medical people have a lot of baggage that we have brought along with us in those areas.

Now but I wouldn’t want to ignore biomedical ethics, cause I think they are key too. There is fundamental injustice when we don’t listen to unborn people and we don’t pay attention to their health, don’t give them a voice. Being a voice for the voiceless is a fundamental justice issue.

Would you put any other issues you put into that curriculum?

Exploration of the human genome that’s with the understanding of God as creator, employer employee situations, different people in the medical team and reimbursement, top down approach to medical decision making, issues such as this.

Would you think it would be important to teach a medical ethics course to pre med students, from a Mennonite perspective?

Oh, absolutely yes, imperative. I was shocked to hear how much teeth pulling they had to do at Goshen, to get something like that in. It seems rather self evident that ought to be part of the curriculum. And 20 years ago it was at Wheaton 20 years ago, so I would have thought Goshen would get right on that band wagon. The ethical wrestle between conflict of interest in modern health care is a pretty intense ethical issues, that ought to be talked about. Whose interest are being served, the dilemma of the reimbursement model and how they effect our decision making. Interestingly, even in the Canadian system, if reimbursement is too high it has the perverse effect of encouraging more procedures to be done, if reimbursement is too low it has the effect of denying procedures. Which is interesting, there is this middle ground where hopefully financial thing wouldn't pry decision making. But that middle ground may be remarkably high considering the normal income expectations. However, anyway, that issues of whose interest is being served, the co-orporatising of medicine. But this is the essence of the doctor-patient relationship, and confidentiality is an element in that ought to be something people understand or get a little exposure to. Autonomy ought to be in there, when an elderly person's decision making capacity is taken away, even though they're fully capable, we already alluded to that. Those are key issues, not just for Christians.

Reproductive ethics is the pet issues. My issue with ethics discussion in Christian medical gathering is, I think we subconsciously steer to the cerebral things that don't pinch us, that don't bite us, they're safe, they give us a high ground to argue from. Which is satisfying but on the other hand, some of these other issues beg a lot more troubling questions of our own lifestyles and the structure of our own practices. If I was an infertility specialist, then my practice would be heavily affect by some of those other issues. But in family practice I got enough ethical issues right on my own plate, so its safer for me to talk about abortion and euthanasia.

Thank you very much, it was very insightful.

1 Dr. Godshall.

2 Mount Joy, PA

3 > general practice, surgeon in Africa, rural setting;

4 > focus: service, justice, distribution, peace, non-violence, being open to those with
5 different understandings = tolerance;

6 > justice for developing world;

7
8 **When you think back over your life and the beginning of your career, are there**
9 **any teachings of the church that stand out as instrumental for your choice of**
10 **career?**

11 I think service is a very big thing. I was just recalling, when I was 15, my Dad
12 was really sick a farmer, and I remember making a contract with God he and if he
13 would get better, to become a missionary doctor. I've been a doctor now for 29 years
14 but only 8 of them have been overseas. But anyway, service is a really high priority.
15 My parents were also weren't interested in talking about peace and justice, that's just
16 simply what Christians did, they were simple guys. My parents led very simple live,
17 they had money but never showed it. They didn't spend a lot on themselves, they
18 gave a lot away. Being in the church, being a church community, those were
19 important things. Service was something that was looked up to. Cause we had forced,
20 young people were, you men had forced conscription, so we had I W service, so that
21 was on our minds, on all of us as children. But then in the late seventies when the
22 mandatory conscription was gone, they would not do it anymore.

23 **So service would be among the important teachings that were instrumental kind**
24 **of, for you to choose to become a doctor?**

25 Yeah, I went to college in the fifties for me, and the options where either teacher, a
26 nurse, or doctor. But because I was the best in my elementary school class, I
27 remember my parents always announced to people that I'm going to be a doctor. SO I
28 had no choice.

29
30 **When you think about your spiritual development, and owning you own faith,**
31 **would be in that journey a place were you find ethics?**

32 Ethics, the things we knew we didn't have sexual affairs. Is that ethics? I
33 mean. how to live, there were certain behavioural things that we were taught, how to
34 behave on dates and stuff. There is really a thing on my mind, I was brought up very
35 conservative. When I went to college, a Mennonite college, I came from a really
36 Repulican area and then going to college and meeting other Mennonites, I went to
37 EMU. And I would say this thing 'you can be a democrat and a Christian?' that was
38 kind of a new concept for me. In fact, I became were liberalised over those 4 years, to
39 the point that going back home felt very uncomfortable to me, but that service motive
40 was there from the start. It seemed to be important. We were into protest against
41 Vietnam, peace and justice was important, that was a justice issue, I guess, suppose a
42 peace issue too. My dad didn't really like that I was protesting in Washington against
43 the government, we should always do what the government says. So that was point
44 of tension.

45 In college we had a lot of discussions about ethics, what should we be doing,
46 should we be protesting, talking to government, how violent can we be, so, I was in
47 the middle of that. You didn't have to be in the middle of that, you could be at the

periphery and not think about it. So I think, doing what's right, living right has always been important. So when I got back to Lancaster County, I did something I never thought I'd do, but I had this 70's optimism I thought everybody should be liberalised like me. we joined this church knowing that there were a couple of farmers who were leaders but had no clue about theology, they knew what the bible says, but they had no training. We tried to read through "the Anabaptist vision" (by HS Bender). It became obvious that we weren't going to get very far, but I think there was a certain optimism to think that we, coming back from college, we could maybe influence people at our church in lifestyle issues and such.

So when you grew up, ethics wasn't something that was talked about publically, it was just something you did? You believed something and you did what was right?

Yeah you didn't talk about it, just do it. When we were teenagers in highschool, we had this bachelors club where we would get together on weekends and we would did a lot of talking about stuff like plain suit, plain dress, head covering, and we had a lot of discussion about how much what the church says should we do, we did a lot of talking about it. We didn't have much options, it was conservative and poor when we grew up, we didn't have options of getting cars and stuff. We didn't have TV, we got a radio when I was about 8 years old, but no TV.

So would you say there are particular Mennonite or Anabaptist characteristics of theology and what would they be?

I guess walking the walk. People who come to our church from other churches, they would say 'you Mennonite people really do take your faith seriously'. What that means is I think is following, discipleship I think that is the key difference. I don't say the other faiths have the right ethics, but often they don't follow, they talk in church and then they don't do it. I think we were taught to do it. That was brought home to me when my daughter married an orthodox Presbyterian. These orthodox Presbyterians, when you talk about service, right away their flags go up and they say 'uhm, one of them who want to earn his salvation', and you don't do that. In fact you don't do service because that might look like earning, its just the way in this tradition, you don't talk about peace and justice and those things because it is like you want to earn your salvation. It has nothing to do with earning your salvation, its just as a Christian you do this. **SO ethics is doing would you say?** With us, ethics is doing, because you believe this, you do this as well. Yeah, but now it seems to be broken down now, we have a lot of Cadillac's and big cars and things, people by things. Now people give 10%, but when I grew up it was 'you give all you can', and that was up to half, to 50%. Where I came from, when I was in two years of service in Puerto Rico I earned about 6000 dollars/year. But then as a doctor in 2 month I earned that much. From 12 month to 2 month. So I come to these MMA meetings here in PA and I ask these older guys, 'what do you do with all this money'? "well, you invest it here, you buy this, so, somehow those guys weren't even talking that kind'a talk. So I don't know exactly where I got it (simple living) but I'm sure I got it from the discussions at college and also living overseas and seeing how people live, that really brings out the justice issue. We really learned a lot in college, how justice

would work out, we just heard a lot of peace and justice talk. I think that was unique for the 50s when I was there.

I was really active in PSR, Physicians for Social responsibility, and I learned a lot what kind of destructive power bombs had and what they cost. That was in the early eighties. And it turns out, my youngest son now, he just graduated from Goshen college, he's sort of in that, he's going beyond where I went. So Goshen must still have it (peace and justice teaching). So he said he's going to cross the line and get arrested, but there were so many that they just shipped them away and never took their names down.

Have you ever encountered situations in your medical practise where your ethics as a physician was colliding with your ethics and theology as a Mennonite?

I have patients asking me to do things, insurance type things, like one has insurance and the spouse doesn't. so write the prescription on one name so its covered or write excuses so I can get off work for a month. So these types patients asking me to do things, but I don't think that's religious convictions, I don't think any doctor should do that. There's times when people come in after being involved with sexual behaviours that I think are very inappropriate and I ball then out about it. There are times when the patients want to do everything, like a patient with a stroke, they want me to do everything rather than just let him die, and I feel strongly they should be allowed to die. I think they should be able to die in peace, but often it is a tension in the family. I don't do abortions, I wasn't taught to as a family doctor. And yet we found in Africa, I did a lot of surgery there because no one did and I was the only one there, I have to take what the person says, and I do a DNC and realise, hey maybe that was an abortion I'm doing. But I had to do what the people said, often it was a language problem. There was a time when I didn't really have time test it, and the people tell you lies. One woman came in and I was doing a C-section, it is her 10th baby, and I have to do it in a way so that when she gets pregnant again and doesn't have a C-section it (uterus?) might rupture and die. So I should tie her tubes and the husband won't agree to it and we're doing it real quick, but I don't have an answer to that.

What is the population that you work with here?

Its a farming community, a veteran community, people work in the cities, lots of farmers but the farming community becomes less and less. Those who stay farmers become huge business people. Rural middles class, but also some really poor people. I had a tragedy just last month this guy came in, he had an accident, hit his head and was on blood thinners, and I tried to convince him he should get this CAT scan, to make sure he not bleeding in there. But he said he felt better, I don't have insurance, I didn't wanna do it, put on his shirt, said he couldn't afford it. But I thought that was a pretty good chance he was bleeding. Sure enough, two hours later he passed out, went to the hospital and sure enough he was bleeding, the next day he died. So its tough, I don't know, should I have forced him, but then you think of his autonomy, you educate people give them their autonomy to make the decisions. But I really thought it was in his best interest to have it done but it was the first time I'd met the gy, he was very insistent that he didn't have money, no insurance. And then on the other hand, his employer is a pastor of a fundamentalist church and doesn't give him

health insurance. So I think now should I be going to this guy and ball him out? I haven't gone yet, I thought about it. There are a lot of ethical issues in that one,

Justice in health care and access to health care is a big thing. There are people who have HMO who want certain things, and if I word it the right way they might get it. If it is medically indicated and all than they will get it paid. On the one hand if they do get it paid than I get less, to me that never has been a real factor, I always got paid much more than I need. The HMO's try to use the 'monetary handle' to try to pry us to doing stuff, but I don't think its forth for me, I do get lots more than I really need. Then there is those that are poor who don't have insurance at all, or are in between medicate and insurance, you know, like this guy. Its more the working class poor. And then there is other people, they don't buy their medicines, they can't afford it, or they like to share them. They share their medicine, he has a cold, and do, so we can share the medication.

So do you think in an association like this one, should there be a development of a particular Mennonite medical ethics?

I'm not sure about a Mennonite medical ethics, the big thing is justice. If we could there to remind people that justice issues are so often forgotten. Somebody's got to speak out for the poor and they oppressed. I think its a matter of emphasis, you know. The church all they talk about now is homosexuality, but forgetting the gap between our people here and our brothers and sisters in Africa. We know its awful but we don't do nothing about it. All that Paul did was collecting money from the rich for the poor people in Jerusalem. Justice would be number one. Why do we spend millions of dollars to keep that 18 week foetus alive and in Africa there is no choice, that baby dies? And here it makes it to 4 month and then dies, 300'000 later. To me that's a justice issue. I don't think one person's life is worth the whole world, even though it says so in the bible. When it comes to money, it just doesn't seem right to put all our resources in one person. Why do we save only one person and let millions die? The tropical diseases are the forgotten diseases of the forgotten people. Millions of people have malaria, for instance, but we don't put any money into it. Where is justice in that?

The other things, I think AB/Mennonites look at Jesus, follow Jesus more than following Paul. If you read Paul you need to read him through Jesus. I think we've been dubbed into this Constantinian-Nicean Creed that completely ignores Jesus life, its not there! He was conceived, he died, he rose again, nothing about his actions, right? And they say this for 17hundred years, this Nicean creed. We AB/Mennonites worked on that a little bit, but not too much. I think with all those new gospels that they have found in the 40th, I think we need to look more at what Jesus actually did. And then also with this pre millennium stuff, like in Israel, yeah, Jesus is coming, the big war is coming, we're gonna be raputred, lets forget about justice, we want that war so we can get out of here. There is a lot of theology that's perverted in our churches, like in the 18th, that rapture stuff.

So justice, and just distribution, and just access would be things you put on the list?

Yes, I think just distribution, individualism is completely foreign to the scripture, I think most of civilisation never though in terms of individualism. In the

last 3000 the bible had to be read within the community: we have resources, we have limited resources, and what are we going to do with it? I read the first chapter in this Rogers book, and thought why can't we have a Mennonite insurance? We say we're not going to have this big open heart surgery stuff, spending lots of money? Then we could all afford insurance? SO, the access of that expensive surgery could help those with no insurance, but well, that's just an idea.

I went with SET to Haiti, when I was a medical student. Africa and Haiti were terrible. So that has been a real concern, peace and reconciliation is important, but other churches do that now too, they look at the Mennonites and see what happens there, but justice is still forgotten.

In what way could peace and reconciliation be applied in medicine, is there a way to apply that at all in medicine?

Oh there are so screwed up families with all kinds of medical problems. There is a lot of fighting now between HMO's and doctors. In the politics of medicine maybe, but in medical practice? In our Lancaster county there are 2 hospitals fighting each other ever since I came to town, competing, the one was bought out.

I guess the way I react at the people who are angry with me. But that's just good PR, if somebody yells at you, you don't yell back, they don't listen. And I don't know whether that's an Anabaptist thing or not. Some of my best friends are my patients, so I have contact with in the parish with, there were certain issues and I listen to them and I was able to hear them. I guess just basically I could hear them, its hard to hear were they're coming from. So ii don't have time in the office to, you know when they're at the stage when husband and wife. come in with their problems, by that time its usually too late, or you send them somewhere else. I don't really know, in the practise, you see?

Justice and compassion? With justice, you see, you get people pretty mad at you, but then you use peace making, compassion could solve our homosexual problem. I think most conflicts have to do with the inequality of distribution, certainly in the international sphere. Marriages break up because of...I think mutuality is important too, some of those things, I don't know whether that is ethics. I think just treating people as equals. I never wanted to be seen like as a God as a doctor, I don't think I've ever come across one of them.

The president of EMU is calling you and he wants you to teach the medical ethics course at EMU for the freshman in the pre-med track. IN your opinion, what would be the absolute must in that curriculum?

Well, I think, let me see, I'm not a teacher. So there are some givens, I mean, we don't wanna kill people, we don't wanna harm to people, you know in the sense "to do no harm", and I think there is really problems to know where the beginning of life is. I think those are the things that should be talked about. I don't think there is any absolutes, I don't know of an absolute answer to that.

And end of life issues, I think those are very important to talk about, I've done a lot of speaking on that, just recently. Make sure that the families do what there parents want, these decisions.

234 And I think in general, attitude of self-giving and not trying to get so much. I
235 mean everything, some of the things that come up, some of my partners accept free
236 trips to Hawaii by drug companies, I think that is absolutely awful. I don't accept
237 anything. Sometimes I walk in and there is a pen on my desk, there it is, I can't to
238 anything. But accepting all those free, you know, we didn't even allow those reps to
239 come in and give our staff a meal while talk about their drugs. Now my partners have
240 broken down, they allow one a month. I still think that's raising the cost, it's got to
241 raise the cost of the drugs. And there is medicare people who can't afford it, they
242 know, they're spending money to send me to California. Those are practical things
243 that should be talked about before people hit, but I don't know... I remember some of
244 them I met in my first year, they gave us all these nice doctor bags, it was just a nice
245 little thing and I was so proud of that, and I took it, I accepted it. Wow, never once
246 gave it a thought, never once. I still have the bag. I still use it sometimes, I never gave
247 it back, you know. Those are the things, people don't think about that. Its sort of like
248 "its free, take it, you don't think about consequences down the line, that sort of thing.
249 and you don't start doing that unless you think about it.

250 SO I think if you can establish a life style that is... For me one of the biggest
251 things is to live below my lifestyle, if you establish a lifestyle and no one can pry you
252 into doing stuff because of money. I mean it has always been important, I made it a
253 point were I can live on about half of what I get. Except for overseas, I didn't get
254 much then, but I've always been able to live on about half the salary I get. It's not
255 really simple lifestyle, its just living like other people. I heard that from 1986 to 1994
256 what people in America really needed to be happy has double in cost, you know with
257 cable and stuff. I don't do that. Maybe it is simple lifestyle in a way, but its a

258 So I guess to me that would an important thing to get across, that we still
259 approach people with equality and not with you know, hold your nose up in the air,
260 you know. I don't know whether that's ethics, but you know that's a big part of I
261 guess Mennonites were not going to be proud.

262 I think the one we've really forgotten is the justice as a group. I have to look
263 in a book to see whats in a medical ethics curriculum. We have this guy, this
264 missionary in his 30s, who was on the mission field and got in an accident, went to a
265 hospital in Florida, and they messed up his trachea and he got brain damage. He was
266 a complete vegetable, but they brought him up to Lancaster and his wife knew he's
267 gonna be cured. And she knew it, and she had a baby after this happened, so she had
268 two kids, one was 2 one was just born. So these two kids watched their father in this
269 hospital for 15 years, in our hospital. He was sort of the medical ethics piece, you
270 know, and she refused to stop the respirator. You know, we had a lot of discussions
271 about that, after 15 years he finally died, what a sad... I mean to me that is a really
272 big ethical dilemma. These poor kids grown without their daddy, with this Mom
273 who..

274 **so let me understand this: they already had a child, and then he had the**
275 **accident, and then she got pregnant again?** No, she was pregnant while he had the
276 accident. And then this Florida hospital had to really pay all his medical bills until he
277 died, so that's why there is not pressure to get her paying up. Even for intermediate
278 care for 15 years in our hospital. SO that was an ethical dilemma we always brought
279 up. I don't know how we should have done it differently, that' the way it was. So
280 there is a lot of things out there to talk about. Its a poor use of resources.

To me, I told my kids, if I'm in a coma for two or three weeks, don't do anymore, please let me go. I don't think its right using all those resources all that time. But somehow, those resources could be channelled to the surrounding hospitals, there would be neat, but it doesn't happen that way in our society, were we save on our Medicaid and Medicare.

It strikes me that you have a strong heart for missions hospital work and things like that?

Yea, I think its terrible how it is. One of my colleagues I worked with for two years, he's doctor, he had hypertension, he was younger than me actually, he's dead. His kidneys failed him, he had no dialysis in Tanzania, we worked together in Tanzania, you know, he dies. Whereas me, I would be on dialysis or having a new kidney, you know, there's something wrong with that. Or even of my friends senior kids of 20 years, who die of malaria and that stuff, it seems, I don't know, its racism, the way I see it. I think if the same thing would happen to our European, or if it happened in Russia, or to Russian Germans or Russian Mennonites, like it did in the 1920s, you'd get MCC and help them. And now its happening to our adopted family in Africa, we don't care. And on the other hand, I don't know what we can do, I think its part of that too. I now have a stack of requests from my friends, who want 50\$ so they can go to school, for the kids, it will never stop, you know. So what'd I do? Do I write, do I send them? Its really daunting. Just let them live a lifestyle that at least their kids don't die.

I was in Africa for three years, in Shirati, and one of my patients went to the hospital, had complications, had heart surgery, had another surgery, he ended up with a 102.000\$ bill and died anyway in a year or two. But this 102.000 could have run this hospital for a year, such a thing you never hear, that money could have run Shirati for a year. Just this one patient overhere, that money could have run Shirati for a year. Those inequalities are just unbelievable. I know a lot of it is a generic problem with the government, and the country and corruption, I don't know what the problems are, they're there, bit its got to be in his [president of Tanzania] hear to correct it. and then you give money to the church and the leader's put it in their pocket, its not easy. But I guess my own vision, my own purpose is just keeping this problem in the fore front, so people can see it, they're not forgetting, and discuss it. I wrote a letter to *The Mennonite* two weeks ago about this issue, just so, its there, people can thing about it, although we don't have answers to that. You can get totally hung up on one issue and I can't think of any other ethical issues just now.

An intersting discussion is, I had this homosexual guy who was a patient of mine for 20 years, it took me 10 year before I realised that he was. And then at one point he had a lot of lower back pains, he's coming in for shots. One day he asks me: "Does God love me?" So what do I say: "Sure God loves you. Why don't you come to our church," I said, and you know, he did!! And I thought, well God loves him why can't we all? And you know he came, that was a year and a half ago, and since then, he got his life changed around, he's been active in the church, he gave his testimony, nobody knew he was gay I think at first. I think people are finding it out when they start dealing with him more, so he didn't come anymore. He went away, he got re-educated so he is now a typist, a transcriptionist, in fact he works for me.

327 and some of these things are really, you know, it really blows my mind, I'm sure its
328 the work of God in his life to do this.

329 Another thing I think, now is we need to look after the Veterans. Vietnam has
330 devastated my generation of guys who had to go, I didn't have to go, I could go to
331 Puerto Rico. And I see so many, many out there who have been devastated by having
332 to be in combat there and then come back, and of course they were not that honoured
333 anymore because we lost that war. And even today, they're really neglected. I feel
334 like we sort of ought to be doing something about that as a peace church. we send
335 them there, we messed them up and still haven't admitted we were wrong. Its sad.
336 And of course, when we were going through it we were protesting, and my church
337 was saying don't do that, but anyway.

338
339 Well thank you very much

1 Dr. Etan Lehman

2 GP, OB-Gynaecology, working primarily in the Amish community of Ohio.

3 > main focus: service, justice, resource allocation, age of consent low in Amish
4 community;

5 > child with brain tumour who decided against treatment at age 14; case was reported
6 by paediatrician but was never prosecuted for child negligence, child endangerment;

7 > AC strong emphasis on equality of every human being, special children (mentally
8 handicapped) often treated with much more care and attention than healthy children;

9 > AC living with the land - teaches children early rhythm of birth/death = greater
10 acceptance of letting go, not prolonging death;

11 > AC community strong on responsible use of resources, not being burden on society,
12 not wanting to get service which can't be paid for = medical treatment only in dire
13 need, but rather let nature take its course;

14 > through inbreeding cystic fibrosis seem to be on increase; elders do tend to be
15 important in mixing young people for marriage;

16 > Lehman needed to earn trust first over the years, now people trust his judgement
17 and do take medical advice serious = tubal ligation if uterus too thin to carry more
18 pregnancies;

19 > important differentiation between conservative Amish (Schwarzenruber) and
20 higher (more liberal?) Amish;

21
22 **When you think back over your life and career, can you think of specific**
23 **teachings that stand out in your mind that were instrumental for your choice of**
24 **career?**

25 You mean for my choice of career? Teachings? I probably decided in
26 highschool, ok, I like biology in Highschool, and I probably felt the one way to use it,
27 in the churches and also at home we were taught service orientation type of thing. So
28 you would have used biology for the researcher, of course, I always loved teaching,
29 but I think I picked the job for the service component. So I think I probably got that at
30 home already, probably at the church, taught by church. Of course then I went to
31 EMU and they were very service orientated. That's what I would say how I got into
32 it.

33 **Any other teachings that you would say has influenced you?**

34 I don't think as much home and home church, but I think maybe more the
35 college setting. Lets see, I think its the theological that throws me off. **I can rephrase**
36 **that, if it makes it easier, faith convictions beside serving. Was there anything**
37 **else that was instrumental?** I don't think I thought of it that way. You know again,
38 helping people but that service oriented. When I was interviewed for medical school
39 they asked me why I wanted to be a doctors, you'd say "because I want to help
40 people". And those who were in it for the money, would say it anyway, you know.
41 I don't think that much of community to be so important, more helping people. I
42 realise that Mennonites being community orientated, but that was not my focus when
43 went into church.
44

45 **Thinking about your spiritual growth and development, where would you locate**
46 **ethics in Mennonite theology, where is ethics located?**

[Ethics] I guess its part of everything. But then in college we took an ethics course, that spelled it out, we verbalised some of the things that I just did. The course made it more solid, spelled it out. Or we talked about things that we did.

Is ethics then something that came with teaching of bible and preaching in the church, or is ethics something that is what we do?

But I think there is just a certain amount of ethics is just being a good moral person. But I think the Christian principles grow from the bible, especially when we look at sermon on the mount, that sort of thing, which I heard all the way through, but I think it was more then solidified probably in college. I think it was called Christian ethics, it was biblical based, well maybe in a secular school you get logical ethics. I would say the course said Christian ethics, but of course it was Anabaptist ethics, because that's the school you went to, and that's what I got. I can't divide ethics from everyday life.

Would you say that there are particular characteristics of Anabaptist theology and ethics, characteristics that Mennonites are known for?

The characteristics, I guess being pacifist, you shall not kill, that type of thing, and then the 10 commandments, about being truthful and that type of thing, again that's something you where almost taught from early up. But then I think later that's been taught, and I would say it was taught but taught black and white about being truthful, murder, that type thing. But then I think later on in medicine its not always quiet that clear. And yet in medicine the policy still holds to 'tell the truth', but sometimes you have to shade or twist it a little bit, not exactly, you almost have to. But then when it comes to euthanasia and abortion, especially passive euthanasia, which there is such thing as passive euthanasia, which I'm sure I practised. Because besides almost the two spectrums I had, I delivered lot of babies, many where premature, so that makes some tough decisions, on the other hand I was the house physician for a nursing home for 25 years, 26 years. And there it was the nurse in charge and I were good friends, she was a Christian, and sometimes the best decision almost was, person that just had no hope, demented and the hole thing, they didn't know where they were, and get pneumonia or something like that. And we'd always say, the best thing would be to do nothing, and sometimes we actually did it. Sometimes regardless we lost the patients, sometimes the patient got better without us doing anything. But we would talk about it, say 'hey, the kindest thing would be to do nothing'. Of course we always respected the family, if the family said to do everything, but some of these people had no family, So see, it wasn't always black and white.

So you took the next question out of my hands already, were in your medical practise the teaching of the church collided ?

I was taught to do this, but is this practical. Let this person just exist, no response, well was like a vegetable, there it was. How long to do it? No family.

In your experience, I understand it is the Amish population you work with, how do you apply scientific medical practise to a very closed, integral community that shapes opinion building quite significantly?

I think, I still try to give them all the option of the best medicine, and I think example. I found with Amish a little , if they had something to cure like a fractured

bone, they would let us use whatever it needed to do that. But when it comes to cancer, then I had to give all the best shots I could, get from the oncologist, what is the percentages, why it is there, what does it do, and that type of thing. And if it was not good, they would rather go home and let nature take its course. Or at that point use their alternative medicine. But I would really encourage it. I myself would have to know these figures from the oncologist, what percentage before I could really tell my patients that they should really at least try "orthodox" medicine first. But when the percentage was not good, I couldn't even push them that far. Because for them it is expensive, they see life as this hard play, it's difficult, and death is not the end, even though I understand from my theology that their theology they don't have the idea that they say they're saved, but they hope they are you know. If they do think that people go to a better place than they say that.

Hardest thing for me is to convince them, but they think I have something [to cure]. I need to put them on a respirator to get them from here to there [hospital], then they see all the tubes and everything else, they think the person will make it, as far as their concerned. But they don't know all the statistics, I am trying to convince them that this is just temporary. Because if it is just temporary, they would rather stop everything. That's the same with new-borns, prematures that I think we just need this help to get from here to there. But then they see the baby has a tube in every orifice, they think the baby's suffering even though it may not be. And then you talk to them about electrolytes and acidbase, and we know we get them through, but they don't understand that. "The baby looks sick, its going to die, so therefore stop everything." It's still hard to convince them

On the other hand once I'm convinced it's the same thing. I back off a lot quicker. I don't push, unless I'm pretty sure the percentages are pretty high that we can still help. But once, to give a chemotherapy to make somebody live 6- 8 month, and lose all the hair and all the side effects, if you give everything and they'd live 8 month or nothing and they live 2 month, they'd go for the 2 month.

But then I think, they don't tell me, but I think, they're decisions are made on financial things. They don't have ex number of \$, they want to pay their bills, they don't want to be a burden to the society. And of course they have large families, 10,12, 15 children, and one is sick, and if its terminal, you know, they don't fight it. And I'm not so sure I could really push and say you have to do this.

Is there a problem in the Amish community with lower life expectancy because of more inbreeding or is that not a problem?

There is some things that show up more often because of some inbreeding. Cystic fibrosis, for instance is one example. Marriage monitoring does not happen to my knowledge. And yet they do try to meet, young people to meet other people, there is some of that going on.

Any issues of birth control or family planning?

The only thing there the issues is you don't do it, but there I'd have to modify that when you use the word Amish, just like any other religious or social group, there is what you call the liberal, the middle of the road, and the strict ones. The strict ones, no birth control at all. I just did one this week, a sterilisation in the strict Amish group (Schwarzendruber) strictly because of health reasons, age and so on. They went along with it, I was surprised they talked to the bishop. Others would just flat

141 refuse, and we really have to talk to them. And then the middle of the road Amish, if
 142 I give a good health reason you know, they'll go along with it. But it has to be a
 143 pretty good reasons. The trust is a really big issue, they know I don't do it unless I
 144 know its necessary. Because we can do a C section, and they will trust me to do tubal
 145 or not if I say the uterus is too thin, you should not have more babies. But if it not
 146 than we don't do it. And I have places where, as much as I liked to have done it, for
 147 medical reasons, they would have trusted me, they left that up to me. They'll sign the
 148 papers in the understanding that I only do it if I really think medically its necessary.
 149 Sometimes ones that I could do it, I don't find a good reason, and then other times...

151 **Has your work in the larger Amish community ever brought out ethical issues**
 152 **were you found yourself bound by oath in conflict situations?**

153 I think maybe earlier on when I was in the mode I can heal everything, that type of
 154 thing. But I think over a period of time, I learned from them that they were more
 155 practical than I thought they were. But I can't really think of any time that they really
 156 put me on the spot like that. I also have to teach other doctors. Every time I get a new
 157 specialist coming to my hospital, I have to teach them how to work with the Amish.
 158 And I'll give you an example.

159 We had a new paediatrician come to town, we had a baby that was early,
 160 premature and I really thought we should let nature take its course, new paediatrician
 161 had a problem with that, felt he had to do everything, send to the referring children's
 162 hospital in Akron, (OH) . Of course then they did all the fancy work, the poor baby
 163 was there a month, in fact almost exactly 30 days, and then died. And I called up
 164 talked to the doctors there, they actually said "probably you should have never send it
 165 up". I've had a hard time teaching the attending paediatricians. So you know that he
 166 did what he probably felt, and the baby died. That's been 10, 15 years ago. They were
 167 paying the hospital bill for years, not months, I mean for years, they send their 25\$
 168 up, the hospital just took whatever they gave until its paid off. I had a hard time
 169 convincing the new Doc.

170 More recent, I'm working with the optometrist. One of my patient went to
 171 him, because it was a 16 year old girl, that had a headache, and went to the
 172 optometrist. When he looked in he saw the bulging of the optic nerve and he was sure
 173 it was a possible brain tumour. So I had to talk to them to get a cat scan, and because
 174 of the cost again the have no money, and also about 10,12 other children, I said 'lets
 175 at least do a cat scan so we know'. Not knowing it, they asked the daughter that she
 176 wanted one, and she did, so we did it and found a brain tumour, inoperable, and she
 177 had headaches. So next thing we want to put a shunt, so at least we leave that in to
 178 relief the pressure, they didn't do that and we really had to corner the parents. And so
 179 I cornered the parents "why not put a shunt in?" And here I found out, I didn't even
 180 know it, they'd had asked the girl and she said she didn't want it. SO with that, I said,
 181 "at what point to let her decide, a minor, you know"; Yet, I had forgotten that, his
 182 brother had a daughter who had leukaemia, and was about 15, 16 years old and I took
 183 care of there, she died years ago. And she said, "well when that girl was sick, the
 184 family left here decide what treatment she wanted, and you respected tha", but I
 185 didn't know it. And the father respected that. I thought, just put a shunt in, would
 186 have just relieved her headache, but they said, she takes her medication, they said as
 187 long as she takes that she is OK. But she said when she tells us she has a headache

188 bad enough and wants it done we will do it. Bottom line, she died, never had it done.
189 I was surprised.

190 This is what I found out (that the children have power to decide) this is kind
191 of new to me, I always thought the parents made all the decisions. With this strict
192 group, with these two cases, but in these cases they let the children make the
193 decision. Which I was even aware of. That was my reasoning, she's a minor, how can
194 you let her decide what its best for her, and then threw it back at me, and said I had
195 respected another one which I didn't even remember. The ruptured appendix, and the
196 daughter didn't want it.

197
198 **Do you think the understanding of the Amish community in letting the children,**
199 **or fairly young people decided is somewhat based in equality in the eyes of God,**
200 **and can decided for him/herself what is best? Or is it more a practical thing?**

201 I think the practical is more the case. And then of course then they had
202 another barb to hold me off. This is just a small group, not all the Amish do that. This
203 was the most conservative group that I experienced that with.

204
205 **When you think of developing a framework for AB medical ethics, what would**
206 **you include in there?**

207 Unfortunately, the most money is spend in a persons life so often in the last
208 year, year and half of life, the last illnesses, that type of thing, unless it is sudden
209 death. I would say, when I look at my Amish folks and also from my AB teachings, if
210 we really believe in afterlife, heaven, all that we talk about, I don't know why if we
211 really have the facts, why we would still put in so much effort to prolong life, or
212 even prolong death. I think we can learn from them, and if we have the facts
213 [statistical outcome of recovery] I'm not sure why we prolong life, or prolong death. I
214 think the tough questions come up with Alzheimer's and demented people. How long
215 do you have to keep these people going? I just think with dementia and Alzheimer's
216 Disease, you can almost make a case for passive euthanasia. I'm not so sure why you
217 would prolong some of these things.

218
219 **DO you think there is a particular Ab medical ethics?**

220 I'm not so sure there is (AB Medical ethics), there is Christian ethics, but is it
221 AB ethics, I'm not so sure. I thought for a long time, I think it was R. H. Clare-
222 Amstutz said, a Mennonite doctor, who said I know I heard it at the nursing home. It
223 was before AHD was as prominent as it is, he said "a person has a right to live, we
224 should do all we can, as long as they are still able to be loved or to give love".
225 Something in that order. But once they passed that stage, you know. Once you lose
226 the mental faculties, why prolong it? **Would you also apply this to the beginning of**
227 **life?** I don't think you can. that's a different issue.

228
229 **So you're saying that a peace position and the non-violence position is not**
230 **necessarily applicable to medical ethics?**

231 I almost say that for practical reasons, I'm not so sure. Maybe I'm influenced
232 a little bit by my Amish people, how much finances can you spend on one person
233 when there is all this other needs. How do you make sure you have healthy
234 perspective. But then, its difficult whose to decide to decide who is healthy who is

not healthy. They fall in that category (of individual worth), and yet they will take care of their Down Syndrome children, they call them 'special children', and they will love them and take care of them. Justice issues; are we treating one child or are we give vaccination to 50 others and prevent 50 others from having problems. That's a tough question.

Theology is the basis for ethics. justice in public health is a really big problem. Higher cost with genetic possibilities, how do you share limited funds among so many people.

If you were asked to write a medical curriculum, what would you put in there from an Anbaptist point of view.

Number one, not everything is black and white, there are going to be some grey zones, but in teaching it comes out as black and white. And then there are though decisions, there is only so many resources for so many problems, how much can you do and still be justified to the others. some of things I think they should be told up front, so that they at least be exposed to it. And that might not mean to much to them but at least they would be exposed to them, and then they would they hey, you didn't tell us back there. And there they tell you everything is black and white, either you do this, or do that. Its not like that.

Does the issue of sanctity of life every come up with the Amish people?

Oh yes, I think its there, I mean with the respect they give to old people and the handicapped who they call their special children, I think they show a sanctity of/[for] life. On the other hand they don't think it has to be extended to the point of prolong[ing] death. What they understand is they just prolong death, they died back there. I think they have a high respect for life, you know, their old folks are cared for, the special children, babies are wanted and taken care of in their own terms.

Connectedness to earth, understanding the beginning and end of things. Also the children grow up, because of large families, the grow up taking care of others, grandparents live with them, they see death, that type of thing. Birth and death, they're exposed to the hole cycle of life better then what we are, we are so isolated. I think they're better equipped.

Well thank you very much for your time.

The eye doctor, he could not live with himself that they didn't do anything, and he reported to the local social children's service. He said I have a problem. Social services went out and they called and I explained everything and they didn't do anything. but he thought is was abuse, it was neglect. Another case a premature was delivered at a local hospital in Ashland, a level one hospital and the paediatrician felt uncomfortable for the baby to stay there, though it wouldn't make it, send it to the children's hospital in Akron. The family refused it, was a Sunday afternoon, actually the grandfather called me, to get out there. They didn't want to do anything, just they best they can. On that Sunday afternoon, they got a court order to move the baby. Got a court order from the judge to move the baby to Akron. It was there a month or so, then the baby went home, they had the baby for 4 month, then there was a hearing

281 again, for the courts to get the baby back, but the family could keep that baby then
282 The other thing is, the family never got a bill from the hospital. They never got a bill.
283

1 Dr. Dan Nafziger,

2 Detroit, MI

3 > Disease Control, public health

4 > main focus: service, justice, resource allocation, public policy, distributive justice,
5 principles of medical ethics, truth telling, informed consent,

6
7 **When you look back over your life and your career, do you think there**
8 **instrumental teaching of the church that might have helped you decide to**
9 **become a medical doctor?**

10 I think that probably did influence my decision, my father was a physician, so
11 I have probably a little different perspective, and I guess I always considered it a
12 possible career, just because I've grown up in a medical family. And so it is a little
13 hard for me to necessarily tease out what I was taught at home vs. what I was taught
14 at church, because I came from a church going family. But I think that it would be
15 true that the churches teachings did influence my decision to go into medicine

16 **Could you pinpoint any particular teachings that you would say were more or**
17 **less instrumental?**

18 I think the service orientation of the church would be the primary thing,
19 because a lot of the other were distinctive Mennonite teachings like related to peace
20 issues. I'm not sure that, although it is important I don't know that I really ever linked
21 with deciding to become a physician. The service aspects.

22
23 **When you review your spiritual development, your growing as a Mennonite**
24 **Christian, is there a place where you say ethics is located?**

25 I did grow up in the Mennonite church, I went to a Mennonite highschool,
26 Mennonite colleges, and I think that I got a lot of biblical and spiritual, and
27 theological teaching through all of those experiences. But I can't really recall even
28 through college ever really getting much in the way of teaching related to ethics as a
29 distinct discipline. And although people complain about how little ethics is taught in
30 medical school, I think that probably would have probably been the first actual ethics
31 teaching that I would have received, as distinct from sort of moral and spiritual
32 instruction.

33
34 **Would you then suspect that ethics is something that just there and its done.**
35 **How would you define a Mennonite ethics if it is existing actually?**

36 I'm not sure there really has been sort of a distinct discipline as far as
37 Mennonite ethics. Theron Schlabach was my college professor maybe that reflects on
38 my perspective, but I guess my sense of this the same as the person asking about
39 Mennonites and higher education. Because when I really, from the people I have
40 talked to its folks that are my grandparents age that would have been the very first
41 Mennonites that I'm aware of that were actually allowed, I don't know if they were
42 even encouraged, but allowed to get a higher education and become physicians.
43 Almost uniformly, at least the people I've met at that generation, that became
44 physicians, they all where missionaries. I mean that was sort of the justification for
45 being able to get a higher education was to go to the mission field and serve. So, the
46 service was the primary driving value in allowing the education that it took to
47 become a physician. I think it was primarily just my dad's generation where

48 Mennonites were actually becoming physicians and not necessarily becoming
49 missionaries. Where they were staying home and serving the rural communities or
50 the cities or wherever. And I think it really is more of my generation where people
51 are branching out into other areas that aren't sort of more strictly service oriented
52 professions. I have a number of people who I know are becoming lawyers, but that's,
53 I can think of a few lawyers a generation up, but that is very few, and I think that's
54 partly why there haven't been Mennonite bioethicists. In some respects its more of an
55 academic discipline, even though its a practical and important kind of discipline, in
56 many respects its more academic in many respects. And Mennonites have shied away
57 from doing things that are more purely academic until sort of our generation.

58 **I haven't yet found a Mennonite wallstreet money broker, or something like**
59 **that, its really hard to find those people.**

60 I don't work in a Mennonite institution, I have lot of my work colleges who
61 are getting MBA's, and I'm sure that Mennonites getting MBA's but its not the same
62 frequency as the general population.

63
64 **When you think of your practice, have you ever encounter a serious collision**
65 **betweenn your theological faith understanding and your ethics and your**
66 **personal practice?**

67 I didn't actually tell you everything I do, I was holding out on you. I am an
68 infectious disease physician, but a lot of my time is actually spend in 'what I call
69 pseudo administration', its not truly administration, but I'm the medical director for
70 an infection control program, so that sort of what you where touching on as far as
71 public health goes. But I also do some things that are touching on quality assessment
72 kinds of things, and I'm the medical director of the risk management program for the
73 hospital and the medical group.

74 And particularly as it relates to risk management almost everything is a sticky
75 ethical problem. Because most of what is done in medicine is done within a co-
76 operative framework. Patients want to get better, doctors want make them better,
77 hospitals, even if they're have an underlying drive for profit, recognise that getting
78 patients better is fundamental to their work. So the framework or the way that people
79 interact is fundamentally a more co-operative one. And in that respect it is one in that
80 a Mennonite feels much more at home in, whereas the legal system in the US is
81 fundamentally an adversarial one, and risk management sits right on the fence of the
82 interface between all of these co-operative folks that are trying to get better and
83 improve health and that adversarial legal system that doesn't have anything to do
84 with health. It has to do with settling disputes. And so I think that's were some of the
85 challenge is in how does one interact with the interface of these two very different
86 way of dealing with these problems.

87
88 **So can you give me like a practical example of what you're dealing with, a**
89 **practical ethical issue?**

90 A practical example that I guess I would think of would be things related to
91 medical error, it has gotten a lot of press in the secular media, and is of great concern
92 to hospitals, patients and physicians alike. Sometimes the values that drive decision
93 making conflict. I mean you can find folks that really elevate beneficence to the
94 highest degree and say "doing good is what were about and its maybe not so

important that patients be completely autonomous and have complete informed consent, because really, informed consent is a theoretical artificial kind of thing and its not something that can be done". And there are other individuals that are very for patient autonomy and informed consent is what is it all about and bringing up beneficence is just paternalistic and we don't need to think about that very much in the way we make decisions.

So for example, we could have a vaccine that we have reason to belief was not stored properly. And what's the correct ethics thing to do? Should we just say, well nobody knows about is, nobody is going to sue us over what they don't know about, should we do nothing? Which is neither doing to beneficence nor to informed consent but does certainly go to the bottom line of the health care institution. Or should we tell people about that and let them make up their own mind about what should be done. But that a pretty easy from my perspective, I don't know if every institution would handle it the same way, but that was were we made an institutional decision that we would contact people, and we'd let them know we provide free vaccine and free testing for them if they wanted it. And we would figure out later whether anyone would be so unhappy as to sue us over it. But that's a practical example.

Where they might conflict? What should we do with errors we know happened but did not result in any kid of injury? What's the institutions duty? To tell people about that? You can look at those problems and recognise that some of them are going to create anxiety for patients, and if you are already completely confident that no injury occurred, do you created that anxiety in patients so you can feel better, have a clean conscience and you inform people and let them figure the problem out? If they're wanna be anxious, that's their own fault, that's though, you know. That's more of the challenging kinds of situations. It is easy when the values all line up, but its harder when you're actually weighing beneficence vs. autonomy.

Do you actually also deal with all kinds of ethical theories? Or is ethical theory not really coming into your decision process?

Honestly I don't know ethical theory enters a lot into my decision process. Some of those are very I mean they are very difficult issues because you can look at justice issues. For example, I might from my position be able to influence what antibiotic we purchase. Whether we have 2 antibiotics that are available for all prescribers or whether we just have one and therefore we are able to save money because of volume discounts with just having one antibiotic. And it can be tough to know how much saving money for the health care system allows that resource to be freed up for other more critical needs vs. saving money for the health care system and you may not actually have control over the fact that it is distributed in a just manner. Vs. someone building an new building and putting up fancy fixtures.

I thing distributive justice is a big issues but not an issue that I feel like I personally have very much of control over in my actual position, although I do a lot of policy advising about administrative matters. I'm not the CEO with the budget to say "we're gonna use this money to provide free vs. we're going to use this money to build a big building to I can name after a big donor". Or after myself, actually when I was in Iowa, the head of the hospital actually had a building named after himself, which yes, a lot of people's reaction as "wow, I didn't even know he was dead yet".

But I think distribute justice they're much more difficult to deal with actually because most of us don't feel that we have control over those resources.

Do you think there are particular characteristics of theology and ethical in Anabaptism or Mennonite theology?

I think so, I'd like to think that the values that I bring to my work as Mennonite are important and that they distinguish me from someone else in my job who would just there to take home an equivalent size pay check and do whatever they want. But we really have not had a field, there hasn't been a field of Mennonite bioethics that has been shaping public debate or I'm not sure even influencing internal church institutional policy. I mean there are groups like MMA that in many respects are very influential in Mennonite church structure, and I'm not sure there has been a group that has struggled with the ethics of how MMA work. Maybe someone within MMA has done that but I don't think there has been sort of a church wide discussion about should MMA be advocating a single payer system to provide health care for people in the US? Or should they be advocating for the banishment of HMO and the return to a fee for service structure to provide care for people. I don't know whether that kind of debate has happened.

So what are the particulars of Anabaptist theology in your opinion?

I think there's sort of two ways to answer that kind of a question. One is to describe the thrust of what Christianity is, which in many respects is probably not what people are asking when they ask those kind of questions. The other is to answer what they're asking is how are Mennonites distinctive from other Christian groups. I think probably the primary values are the more important values, I guess it depends partly whether you view things in both/and or either/or.

I would like to think that the Mennonite approach to Christianity is a correct one and is very much exactly overlapping what Christianity is and should be. It depends on sort of how narrowly you want describe Christianity as being distinctive from being Mennonite? I think the primary values that I think are the most important ones that I sort of view as Christian rather than distinctly Mennonite. I mean the things that's Mennonites have held as more distinctive from other Christian groups had been the peace position, and certainly sort of community behaviours and operating within a community framework, and I think also the way we structure our church life. With congregational model being primary rather than a pope telling us what 4 bioethical principle would be and us following those have shaped what a sort of more purely Mennonite vs. other Christian group. However, I don't know that that congregational decision making model helps us much in bioethics, it might help me attending a moderately liberal Mennonite congregation in Ann Harbour where there are half dozen other physicians, but it might not help my father going to church in a more rural area in Ohio, where he is the only physician with a lot of people who did carpentry and farming. I'm not sure that that part of being Mennonite is much help in the realm of Medical ethics.

The peace position, it certainly influences I think a lot of the ways you might approach issues at both ends of the life spectrum, abortion and dealing with pre mature infants and so forth, and with death and dying. But I don't know that impacts as many of the ethical decisions that we face as things like justice and being a

servant. And some other things that I see as more core Christian values rather than distinctive Mennonite values. I don't know, maybe the service is more a distinctive Mennonite value than I appreciate, but I have friends from other denominations who certainly view service as an important option.

One if the real conflicts I think is that most of the distribute justice issues are really been tackled at a mostly federal governmental, but some state governmental level. And Mennonites historically had been quite uninterested in interacting with politicians in either of this levels.

If there is a Mennonite Medical ethics, what is Mennonite medical ethics?

I guess I don't know whether the secular labels of beneficence and justice and maleficence are really any better labels than the kind of basic theological teachings that I consider more Sunday school material of 'love thy neighbour as thyself'. And if your enemy ask for the cloak of your back give him the shirt also. I mean a lot of the fundamental teachings about what it is to be a Christian, I think are the kind of fundamental values that need to make up Mennonite Ethics. So I think doing to others as you have them do unto you is not very far from beneficence in terms of its practical application, and I think that is a core value. I think what secular ethicists hav[ing] a fairly difficult time dealing with are issues like forgiveness, and issues like death and [the place] where death fits into the human life experience. I think those are things that would be sort of the more useful or distinctive things that Mennonites could work on and bring to the table. I think even if people don't always behave as if they belief in something like justice, that justice, fairness you don't have to be a Christian to understand, and so I would think that that's an important value but its not necessarily something that's distinctively Mennonite. SO I'm not sure when you ask for the 5 core values whether you're asking for the five distinctively Mennonite values or the five Christian values are?

What would be the important values for YOU if you were asked by MMA to put it together?

Well I would thing beneficence, I would think doing no harm should be there, justice needs to be there, autonomy needs to be there, and there are certainly parts of my Mennonite background and my belief in freedom of religion that support a very strong stands behind autonomy as core principle. But I guess that's one of the areas I find in a practical sense I struggle the most with, is how fictional is informed consent and patient autonomy, and am I doing something to make myself feel good. I can pretend to give informed consent to someone and then I can feel better and go about my business. Vs. the reality of being able to deliver informed consent to someone. So those I think are values, but I'm not sure.

I think I struggle as much with those is related to my Mennonite value of truth telling which I'm not sure I'm able to do like I like I want to. And so I sort of feel if I'm trying to pretend when I don't really in my heart believe that I'm able to achieve that goal, that I'm being dishonest and that's a problem for me as a Mennonite. I think truth telling is a very important value but I think that's probably one of the ones I struggle with the most because I think in reality from a practical functional day to day working out of medical ethics that beneficence is a much more practical workable value. And its not that I don' t belief in truth telling its just that I'm not sure how well we're actually able to ever do that. We squeeze to the 8 min

clinic visit or whatever, its very difficult. Part of it is influenced by my practise, in that my clinical practice is in patient infectious diseases, were a lot of the work is recommending diagnostic tests and antibiotics. And realistically, you can go in and tell a patient about some of the side effects of the medication, but to actually give them good informed consent you'd basically have to teach them everything you know about all the different antibiotics you could choose from and all their side effects, and all the possible diagnostic tests, and all the different probabilities that go with those diagnostic tests, and its not a very practical thing to be able to do.

So in your work then beneficence is also something that is very close to truth telling, and is kind of the underlying issue of holding another power, because there is already a selective process you do before you get to the patient and recommend that antibiotic over the other, in your professional opinion that is the best one. but then on the other hand, how much informed consent does the patient have really?

You know its complicated enough just to try to imagine discussing the 10 antibiotics to chose from or whatever, but then if I really was gonna be truthfull I probably should discuss everything that went into the formulary decisions. When I have that 10 antibiotics I theoretically could be discussing that's maybe one out of the 10 classes or whatever, its not , well why we use this over that antibiotic, cause the one is priced 45% more and the spectrum is about the same, and the company is gauging us and doesn't want to lower their price to an affordable level, so we're using a cheaper antibiotic that you know maybe doesn't get into your spinal fluid as well as the other.

The president of Goshen College is calling you saying we need a Medical Ethics curriculum. We heard that you didn't feel quite prepared to enter medical school with what you got. What are the most important things you put in that curriculum? Maybe 5 of them?

I guess I would, if I had to teach that course, I'd probably would start with sort of the more secular approach to Medical Ethics that is more widely discussed. Then I probably I would bring in cases examples of some of the practical things and ethical problems people struggle with, then I probably move to readings from the bible and church theology and talk about how our values might tweak this general framework of ethics and how we might do things differently. And I think distributive justice might be something that a little bit different between mainstream bioethicists and Mennonite approaches.

I don't think there is a coherent Mennonite bioethical approach at this point in time. So we need someone to pioneer the charge and bring that curriculum to life.

I do believe in collective wisdom as part of Mennonite theology which needed to come to application.

But there are somethings like human sexuality related questions, there are Mennonites just all over the map at the very quite furthest extremes, maybe not so much in abortion. But I can imagine that there probably some Mennonite pro choices feminists out there and there are probably a lot of staunch pro life Mennonites as well. And that's part of the difficulty with the congregational model, is that you just need get a group of people that think alike and you have 'the churches view'.

283 Whereas when you start assembling all these congregations together, they may not
284 come up with a coherent view.

285

286 Well thank you very much for another helpful approach.